# Commonwealth of Kentucky
# Kentucky Employee Health Plan
# Seventh Annual Report

**Prepared for:**

**Commonwealth of Kentucky**

**Governor**

**General Assembly**

**And**

**Chief Justice of the Supreme Court**

**October 1, 2007**

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# EXECUTIVE SUMMARY

## The Purpose of this Report: Scope and Process

In accordance with the provisions of KRS 18A.226(5)(b) enacted by the 2000 General Assembly as a part of Senate Bill 288, this document comprises the seventh Annual Report from the Kentucky Group Health Insurance Board to the Governor, the General Assembly, and the Chief Justice of the Supreme Court on the status of the Public Employee Health Insurance Program (PEHI), renamed the Kentucky Employee Health Plan (KEHP) in 2007.

The report includes:

- A review of the history and development of the Public Employee Health Insurance (PEHI) Program.
- A summary of experience for the Commonwealth's PEHI Program for the 2006 calendar year with comment where applicable on the first six months of 2007 experience.
- A detailed analysis of pharmacy benefits.
- A section on Health Improvement, Quality of Care, and Cost and Quality Transparency.
- A summary of legislated health insurance benefit mandates and other mandates passed by recent General Assemblies that affect the Public Employee Health Insurance Program.

To prepare this report, research was jointly conducted by the Department for Employee Insurance (DEI) and PricewaterhouseCoopers LLP (PwC). It has been reviewed by the Board and modified to incorporate a full and accurate representation of the Board's findings and recommendations.

Please refer to the *Glossary* at the end of this report for definitions of terms used in the body of the report.

## Board Recommendations

The Board recommends the following:

- The Board recommends that the due date for the Annual Report to the Governor be extended from October 1 each year to December 1.
- Conducting a study to determine the cause(s) of, and tactics for improving, the population's increase in cost. Determine, for example, if there are specific clinical conditions, health behaviors, and/or utilization patterns that could be improved. The results of the study will be reviewed by the Board for feedback.
- Working with the disease management vendor to compare the top clinical conditions that are driving costs. Assess the impact of developing incentives and additional outreach programs to increase participation and return on investment for these conditions. Share the results of this assessment with the Board for review and feedback.

- Conducting a risk study for the population that models expected health risks that may be driving high costs and/or high utilization (e.g., obesity and low physical activity risks and resulting clinical conditions). Based on the risk study, investigate the impact of developing a strategy to implement an overall health improvement program that will promote a "culture of wellness" while providing incentives and rewards for participation. The study would be reviewed by the Board for feedback.
- Considering the impact of managing the generic prescription drug utilization through a member-pays-the-difference program and/or copay incentives to sustain a 60% or higher generic utilization. The Board will review the results and provide feedback.
- Reviewing brand name single source prescription drug discounts for both retail and mail to determine if they are at current market levels. The Board will review the results and provide feedback.
- Investigating the impact of discouraging the use of multi-source brand drugs through a member-pays-the-difference program or through an increased step therapy program to achieve a utilization of less than 3%. The Board will review the results and provide feedback.
- Assessing the current pharmacy mail order program to determine if copay designs ensure that mail order is cost effective (or the retail equivalent). If so, assess the impact of implementing a mail order (or the retail equivalent) incentive program, and if not, investigate the impact of adjusting copays. Further, evaluate whether or not the associated discounts are at best market levels. Consider the impact of implementing a mail order (or the retail equivalent) incentive program. For example, consider a program that, after allowing an initial fill and two refills at retail outlets, requires that the next prescription be submitted to mail order (or apply mail order provisions as a retail equivalent). The Board will review the results and provide feedback.
- Investigating the impact of participating in a specialty pharmacy program which would provide 24/7 access to a pharmacist or nurse specialist to members, cover all necessary supplies for medication administration, and ensure appropriate utilization and adherence to prescribed regimen. The Board will review the findings and provide feedback.
- Considering the impact of refreshing plan designs for both medical and pharmacy benefits. This evaluation would be reviewed by the Board for feedback.

## Background and History

The *Health Insurance Market for Employees and Retirees of Kentucky State Government – Research Report No. 286*, prepared by the Program Review & Investigations Committee Staff and dated August 12, 1999, provides the following historical context for the Commonwealth's Public Employee Health Insurance (PEHI) Program:

> *The Commonwealth first contributed funds for the health insurance premiums of its employees in 1972*. From that time until the mid 1980's, Blue Cross & Blue Shield was the only insurance carrier offered to the state group. After experimenting with two HMO plans in 1981 and 1983, the Personnel Cabinet made more than a dozen additional plans, mostly HMOs, available to employees in 1984. Still, the indemnity plan offered by Blue Cross & Blue Shield was the dominant plan chosen. Of the 90,000 employees eligible for state-provided insurance in 1987, 64,000, or 71 percent, were enrolled in the Blue Cross & Blue Shield Key Care indemnity plan.*
>
> *In September 1987, Blue Cross & Blue Shield notified state officials of its intention to cancel the Key Care plan on October 15, 1987. This led to a decision by state policymakers to self-fund the healthcare program under the name Kentucky Kare.*
>
> * *Note: The Commonwealth first contributed funds for the health insurance premiums of teachers in 1972. However, the Commonwealth began contributing funds for the health insurance premiums of other state employees prior to 1972.*

As part of extensive changes to health insurance laws adopted in HB 250, the 1994 General Assembly established the Kentucky Health Purchasing Alliance (Health Purchasing Alliance), which became effective for "Public Employee Health Insurance (PEHI) Program" members effective July 1, 1995. Under the Health Purchasing Alliance, from mid-1995 through 1998 PEHI Program members had a choice of five Kentucky Kare options. In addition, PEHI Program members could also choose from among four HMO options, four POS options, or five PPO options—all offered through a variety of insurance carriers.

Due to mounting losses under Kentucky Kare as a result of adverse selection resulting from diminishing enrollment, the 1998 General Assembly enacted House Bill 315 which dissolved the Health Purchasing Alliance effective December 31, 1998. This led to the Commonwealth re-establishing an independent healthcare program for PEHI Program members called the "Commonwealth Public Employee Health Insurance Program."

## Modifications to the PEHI Program, 1999 to 2007

Beginning in 1999, the PEHI Program offered two HMO options (A and B), two POS options (A and B) and two PPO options (A and B) through insured arrangements with seven insurance carriers including Advantage Care, Aetna, Anthem, Bluegrass Family Health, CHA Health, Humana, and PacifiCare. In addition, two indemnity plan options were offered to out-of-state retirees through Anthem.

**In 2000:**

All of these plan options continued to be offered, with the following principle adjustments:

- An EPO option was added to provide PEHI Program members with the choice of a plan with a lower employee premium contribution.
- The insurance carrier, Aetna, was no longer offered by the Program as an outcome of the 2000 Request for Proposal (RFP) process.
- A feature was added to all plan options that reduced the prescription drug co-payments after a member pays 50 co-payments in a year for themselves or covered family members.
- Coverage of outpatient mental health/chemical dependency services was expanded from:
  - 30 to 45 visits annually for the "A" options, and
  - 21 to 36 visits annually for the "B" options.
- Out-of-state retirees were allowed to enroll in any POS or PPO option offered by any of the Commonwealth's insurance carriers since no carrier was willing to insure an indemnity plan for those retirees.
- The Commonwealth revised its member subsidy policy to provide for a subsidy that was at least equal to the Single premium rate for the lowest cost Option A in every county.

**In 2001:**

- The insurance carriers offering health insurance coverage to members of the PEHI Program changed as follows:
  - Aetna was re-introduced as a healthcare option for the PEHI Program in twenty-eight Kentucky counties.
  - Anthem expanded its PPO service area for members by fourteen counties.
  - Advantage Care ceased to exist.
  - PacifiCare stopped offering health insurance to anyone in Kentucky.
  - Bluegrass Family Health expanded its service area for members by nine counties.
  - CHA withdrew its HMO and POS options from twenty-three counties; however, it introduced PPO options in four eastern counties in eastern Kentucky where it previously offered only HMO and POS options.
  - Humana discontinued its KPPA HMO for PEHI Program members.
- The following changes were made to the benefits offered by the plan:
  - Prescription drug co-payments in the PPO B option were reduced. For generic drugs, the member's co-payment decreased from $15 to $10, for brand name drugs from $20 to $15, and for non-formulary drugs from $40 to $30.

- The cost for members in the PPO A option for diagnostic tests, performed in a setting other than a physician's office, was changed from a 20% co-insurance after meeting the annual deductible, to a flat $10 co-payment.
- Inpatient (per day) and outpatient (per visit) limits on mental health and substance abuse services were eliminated from all the PEHI Program's health insurance options, in accordance with House Bill 268 enacted by the 2000 General Assembly.
- Benefit coverage for amino acid preparations and low-protein modified food products was added to all of the PEHI Program's plan options pursuant to House Bill 202 enacted by the 2000 General Assembly.

**In 2002:**

- In response to requests from Legislators and members of the Commonwealth's PEHI Program, the Commonwealth adopted two new requirements that must be met before a prospective health plan (bidding as part of the RFP process) could be offered to members of the PEHI Program in a particular county. Before it can be offered in a county, a health plan must:
  - Include at least one hospital in that county in its network, provided one or more hospitals exist in the county and any other bidder includes at least one of those hospitals in its network; and
  - Include at least 25% of the largest number of physicians in any other bidder's network for that county.
- In an effort to lessen the potential impact of adverse selection (i.e., when a person takes the likelihood that they'll need medical care into account when choosing a health plan, often resulting in "more costly" individuals in one option and "less costly" in another), the Commonwealth stipulated that a health plan's B option premium rates must be at least 5% lower, but no more than 10% lower than the A option premium rates for the same plan type (i.e., HMO, POS or PPO) and coverage level (i.e., Single, Parent Plus, Couple or Family).
- The following changes in carrier offerings occurred:
  - As in 2001, Anthem expanded its PPO service area for PEHI Program members by fourteen counties.
  - Aetna was discontinued as an offering for PEHI Program members in eleven counties.
  - While Bluegrass Family Health's HMO and POS options were newly offered in five counties, these options were discontinued in three counties. Bluegrass Family Health's PPO option was no longer available in one county where it was available in 2001. However, this option was newly introduced in eight countries.
  - CHA's HMO and POS options were discontinued in fourteen counties and newly added in thirteen counties. Its PPO options were added in four counties, but discontinued in the four counties where offered in 2001, due to provider contracting difficulties.

- Humana's HMO and POS options were no longer available in three counties where offered in 2001 and its PPO options were discontinued in ten counties.

**In 2003:**

- Again, in response to requests from Legislators and members of the PEHI Program, the Commonwealth tightened the network requirements applicable to 2003 bids:
  - The 2002 RFP hospital requirement was continued.
  - However, to qualify as an offered health plan in a particular county in 2003, a health plan's network had to:
    - Include at least 25% of the largest number of primary care physicians in any other bidder's network bidding for the same plan type (i.e., HMO, POS or PPO) for that county; and
    - Include at least 40% of the largest number of specialist physicians in any other bidder's network bidding for the same plan type (i.e., HMO, POS or PPO) for that county, provided any bidder has more than five specialists in a county.
- Aetna did not respond to the Commonwealth's RFP, as it was not willing to continue to provide health insurance to members of the Commonwealth's PEHI Program. This affected eighteen counties and about 8,500 employees/retirees.
- Anthem withdrew from fifty counties, affecting around 15,600 employees and retirees.
- Bluegrass Family Health extended coverage to eight additional counties; however, due to either the Commonwealth's more stringent network requirements or termination of some providers' contracts, Bluegrass Family Health wasn't an option in six counties in 2003 where it was available in 2002.
- While CHA did not extend its service area to include more Commonwealth counties in its 2003 bid, it did extend its HMO and POS options to six additional counties and its PPO option to 46 additional counties. However, it failed to meet the Commonwealth's 2003 network requirements in two counties where it was available in 2002.
- Humana extended coverage (PPO only) to two additional Western Kentucky counties. However, due to its failure to meet the Commonwealth's 2003 network requirements, Humana failed to qualify in 2003 as an option in fourteen counties where it had been available in 2002.
- The following changes were made to the benefits offered by the plan:
  - Coverage of dental services was limited to care required as a result of an accidental injury, including anesthesia and hospital services that are medically required to safely provide dental care for children below the age of nine and persons with serious mental or physical conditions.

- As specified in SB 152, enacted by the 2002 General Assembly, coverage was added for hearing aids and related services for persons under the age of eighteen, up to one hearing aid per impaired ear, up to $1,400 every 36 months.
- Coverage limits were revised for low-protein modified foods and medical formulas for individuals with inherited metabolic diseases.
- Coverage of routine vision care was eliminated.
- A mail order pharmacy feature was added to allow members to receive a 3-month supply of maintenance prescription drugs for a 2-month co-payment.

- Finally, as enacted by the 2002 General Assembly:
  - Through HB 821, PEHI members were allowed to select coverage in a contiguous county and receive the Commonwealth's subsidy for that county, if the hospital in the county where member lived and worked did not offer certain services and a hospital in the contiguous county did.
  - Through HB 846:
    - restricted PEHI employees and retirees to one state subsidy for health insurance,
    - required entities participating in the PEHI Program to sign a contract with the Personnel Cabinet, and
    - allowed PEHI members to select coverage in a contiguous county and receive the Commonwealth's subsidy for that county, if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does (same provision as HB 821).

**In 2004:**

- The 2003 RFP hospital requirement was continued; however, the physician network requirements were modified such that the specialist physician network requirement only had to be met in counties where at least one bidder reported ten or more specialists, rather than in counties with five or more specialists as applied in 2003.
- The point at which members' prescription drug co-payments are reduced was increased from 50 co-payments per year, for a member and all his/her covered family members combined, to 75.
- Coverage was not available through Anthem under the PEHI Program. This affected sixteen counties where Anthem offered PPO coverage to PEHI members in 2003
- Humana:
  - Discontinued offering HMO or POS options to PEHI members, except in six northern Kentucky counties.
  - Failed to meet the Commonwealth's network requirements, with respect to its PPO options, in three counties where it offered PPO coverage to PEHI members in 2003.

- Extended PPO coverage options in forty counties.

- Bluegrass Family Health failed to meet the Commonwealth's network requirements in one county where it offered PPO coverage to PEHI members in 2003; however, it extended PPO coverage options in eight counties, and HMO and POS options in four counties.
- CHA newly offered HMO, POS, and PPO options in two counties.
- Through the Governor's executive order, the Commonwealth provided a health insurance subsidy for employees electing the PPO A option dependent health insurance under the lowest cost carrier in the 21 counties where the cost of this coverage exceeded the cost in the other 99 counties. This subsidy was set to an amount in each affected county that resulted in all employees paying the same employee contribution, for all coverage tiers, for the lowest cost PPO A option.
- Legislation enacted by the 2003 General Assembly:
  - Through HB 95, the requirement that an employee's employment must be in the same county as his/her residence for the employee to be eligible to elect coverage in an adjacent county and receive the Commonwealth's subsidy for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does, was removed.
  - Through HB 430, the service required for KRS participants to be eligible to participate in the PEHI Program was increased from five years to ten years for individuals hired on or after July 1, 2003.

**In 2005:**

- The Request for Proposal (RFP) was released with the following benefit changes:
  - The benefit options for the HMO, POS, and EPO plan types were removed.
  - The RFP included three (3) PPO Options for which bids were requested. These options include and are entitled:
    - "Commonwealth Essential"
    - "Commonwealth Enhanced"
    - "Commonwealth Premier"

    (Please refer to the 2005 Plan section of Appendix A for a description of each of these options.)
- The RFP was released requesting carrier bids across six different scenarios. The scenarios were:
  - One vendor, per geographic region, under a fully-insured arrangement;
  - One vendor, statewide, under a self-insured arrangement;
  - One vendor, per geographic region, under a self-insured arrangement;

- One vendor, statewide, under a fully-insured arrangement;
- One vendor, per geographic region, under a fully-insured arrangement (with alternate network access requirements, noted below); and
- One vendor, per geographic region, under a self-insured arrangement (with alternate network access requirements, noted below).

Please refer to Appendix B, 2005 Geographic Regions, for a map showing the geographic regions.

A *fully-insured arrangement* is the type of healthcare funding arrangement currently used by the Commonwealth. It requires insurers to assume the full risk of all the state employee healthcare costs in exchange for premium payments from the state. In contrast, a *self-insured arrangement* is one in which no insurance company collects premiums or assumes risk. Instead, the state would—in effect—act as its own insurance company, assume the cost risk and pay actual claims with the money normally earmarked for insurance company premiums.

- For scenarios one through four, the following network requirements had to be met:
  - Hospital Requirement: If one or more hospitals exist in a county, the vendor must have at least one of the county's hospitals in its network, unless no bidder for the county, under the scenario being considered, have any of that county's hospitals in its network.
  - Physician Requirement: The vendor must have at least 25% of the county's PCP's in its network. If there are ten or more specialist physicians submitted as practicing in the county, the vendor must have at least 40% of the county's specialist physicians in its network.
- For scenarios one and three the following requirements were in addition to the above:
  - Must meet both hospital and physician network requirements in 85% of the counties within the region and in counties where at least 85% of the group members reside.
- For scenarios two and four, the following requirements were in addition to the above:
  - Must meet both hospital and physician network requirements in each of the eight in-state regions in 85% of the counties within a region and in counties where at least 85% of the group members reside.
- For scenarios five and six, the following network requirements had to be met:
  - Hospital Network Requirement: The vendor must have at least one network hospital in 75% of the counties having a hospital in each region.
  - PCP Network Requirement: The vendor must have at least eight PCPs per 1,000 eligible Commonwealth members per region. Additionally, each vendor must have at least one PCP in each county where it has a hospital.
  - Specialist Network Requirement: Vendor must have at least six specialists per 1,000 eligible Commonwealth members per region.

- Contracts were signed and the following carriers were awarded the following regions:
  - Anthem was awarded Region 1 and Region 2 under a self-insured basis.
  - United Healthcare was awarded Region 3 and Region 6 under a fully-insured basis.
  - Bluegrass Family Health was awarded Region 4 and Region 5 under a fully-insured basis.
  - CHA Health was awarded Region 7 and Region 8 under a fully-insured basis.
- For the first time in many years, Humana was not awarded any area in the Commonwealth.
- For the first time, the employee's cost for health insurance was based on their salary.
- For the first time, the Commonwealth offered an additional subsidy to employees that did not smoke.
- Out-of-state retirees were assigned to the county of their last employment for purposes of selecting healthcare. This created concern from the out-of-state retirees who worked for the state or for those that retired from Regions 4, 5, 7 and 8 because Bluegrass Family Health and CHA Health were regional carriers and did not immediately have a nationwide network. This caused members to accept out-of-network benefits.
- Because this was the first major benefit change in a number of years, state employees and teachers (led by the Kentucky Education Association) held protests throughout the Commonwealth, many were bused to Frankfort for a day of protest and teachers threatened to strike.
- After several weeks, Governor Fletcher called the General Assembly into a special session to deal with the shortage of money available to fund the program. As a result of the special session, HB 1 was passed. In summary, HB 1 made the following:
  - Retained the Commonwealth Essential Option Plan and removed the Commonwealth Preferred and Commonwealth Premium Options.
  - Restored the 2004 PPO A plan benefits as the Commonwealth Enhanced Option.
  - Offered the Commonwealth Premier Option.
  - Provided additional funding for these three options, including additional dependent subsidies.
  - Set the employee contributions as outlined in HB 1.
  - Restored the employer contribution to the healthcare FSA for employees waiving coverage to $234.
  - Required the Personnel Cabinet to submit the benefits for the 2006 Plan Year to the Employee Advisory Committee thirty (30) days prior to the release of the Request for Proposal.

- Created the Blue Ribbon Panel on Public Employee Health Benefits for the purpose of examining all aspects of health benefits available to public employees including the procurement process, benefits offered, plan membership, implementation, maintenance and administration of the plan; alternative methods of providing benefits and services, and any other issues related to public employee health benefits the panel determines to be relevant.

**In 2006:**

- An RFP for the 2006 Plan Year was released, marking a dramatic change in the Commonwealth's strategy for providing employee healthcare benefits. This RFP solicited bids for:
  - A single vendor to provide Third Party Administration (TPA) services on a state-wide basis;
  - A single vendor to provide Pharmacy Benefits Administration (PBA) services on a state-wide basis; and
  - A single vendor to provide administrative services for Flexibles Spending Accounts (FSA), HIPAA and COBRA. The contract for these services was to be awarded to the vendor for medical TPA services, but was structured as a separate contract to provide flexibility to the Commonwealth in future years.
- The Commonwealth moved from a program that had historically been fully-insured to a program that was self-insured statewide.
- Emphasis was placed on experience with a large employer group, having at least 100,000 covered lives.
- A national provider network was also critical to a successful bid, to ensure adequate provider networks for out-of-state retirees.
- To provide further emphasis to this change in direction, the plan was given a name change, and is now called the "Kentucky Employees Health Plan."
- Benefits for 2006 would remain the same as those offered in 2005, with the same three benefit plan options available:
  - "Commonwealth Essential"
  - "Commonwealth Enhanced"
  - "Commonwealth Premier"
- Contracts were awarded and signed as follows:
  - Humana was awarded a contract for medical claims administration
  - Humana was also awarded a contract for administration of Flexible Spending Accounts, HIPAA and COBRA
  - Express Scripts was awarded a contract for pharmacy benefits administration

- For the first time, contracts were awarded for a multi-year term. The initial term of the contracts was 30 months, with eight (8) optional one-year renewals – meaning the contracts could be in place for ten and one-half years.
- None of the insurance carriers who had provided coverage in 2005 were awarded contracts for 2006:
  - Bluegrass Family Health and CHA Health did not meet the minimum vendor requirements and were ineligible to bid; and
  - Anthem and United HealthCare were not selected.
- The incentive for those employees who don't smoke was continued in 2006, with a $15 per month incentive for employees with single (employee-only) coverage, and a $30 per month incentive for employees who chose to cover their dependents.
- Employee contributions did not change from 2005 to 2006. The Commonwealth absorbed any claims or other costs in 2006 that are above the employee contributions.
- The Commonwealth's contribution for those employees who waive coverage was reduced again, from $234 per month, to $200 per month, for the period July-December.
- Legislation passed during the 2006 Regular Session of the General Assembly (HB380) mandated a 12% reduction in the employer contribution amount for July-December, effectively reducing total monthly premium equivalents by about $10 million per month, to about $85 million. There was no corresponding decrease in employee contributions.

**In 2007:**

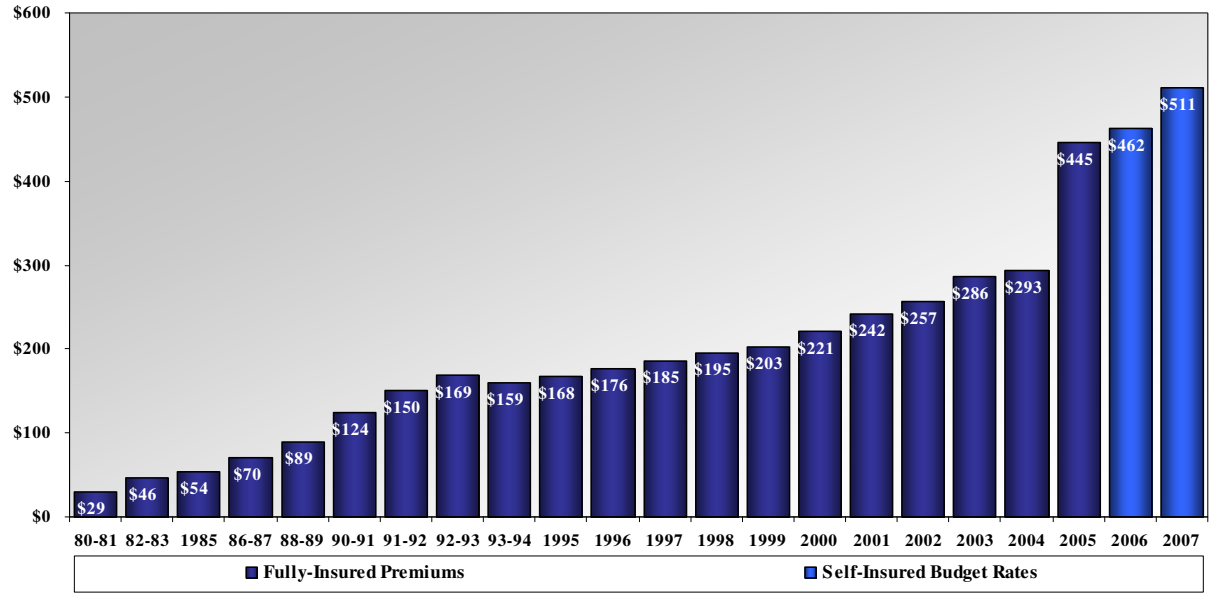
- The Commonwealth offered an additional 4$^{th}$ benefit plan option, Commonwealth Select. Commonwealth Select is a high-deductible PPO with an embedded Health Reimbursement Arrangement (HRA) funded by the employer, as follows:
  - Single coverage - $1,000 contributed to the HRA;
  - Couple coverage - $1,500 contributed to the HRA;
  - Parent-Plus coverage - $1,500 contributed to the HRA; and
  - Family coverage - $2,000 contributed to the HRA.
- Contracts with Humana (medical claims administration, flexible benefits, disease management, case management & utilization management, and HIPAA/COBRA administration) and Express Scripts, Inc. (pharmacy benefit administration) were maintained as in 2006. The current contracts expire June 30, 2008, and have eight (8) one-year renewal options.
- For the Essential, Enhanced, and Premier Plans, the benefits remained unchanged from the 2006 plan year.
- Premiums increased only 5.93% from 2006, reflecting a successful transition to self-insurance.

## Historical Per Employee / Retiree Commonwealth Health Plan Subsidies

The Commonwealth's per employee subsidy from the 1980 plan year through 2007 is illustrated in Exhibit I below. The Commonwealth's average monthly subsidy toward the cost of an employee's health insurance coverage (for those who have elected coverage) has risen from $9.72 per month in 1972 to $445 in 2005, $462 in 2006, and a projected $511 in 2007.

The Commonwealth significantly increased its subsidy for employee health insurance in 2005. Even with this increase there was not a significant decrease in the number of employees waiving coverage.

***Exhibit I***
**Historical Commonwealth Per Employee Per Month (PEPM) Health Benefit Subsidy For Those Electing Coverage**




*Source: Sixth Annual Report and Commonwealth's enrollment and claims data aggregated by MedStat.*

Commonwealth subsidies through 2005 are based on the total fully-insured premium amounts paid by the PEHI/KEHP program less employee contributions. In 2006, the benefit plans' funding changed from fully-insured to self-insured, effectively removing the insurance companies' margins from the cost basis. The basis for the self-insured costs in 2006 and 2007 is incurred claims plus administrative fees, without an insurance company margin. This change in funding had the effect of maintaining the Commonwealth's estimated 2006 subsidy at roughly the same level as experienced with the fully-insured 2005 premium.

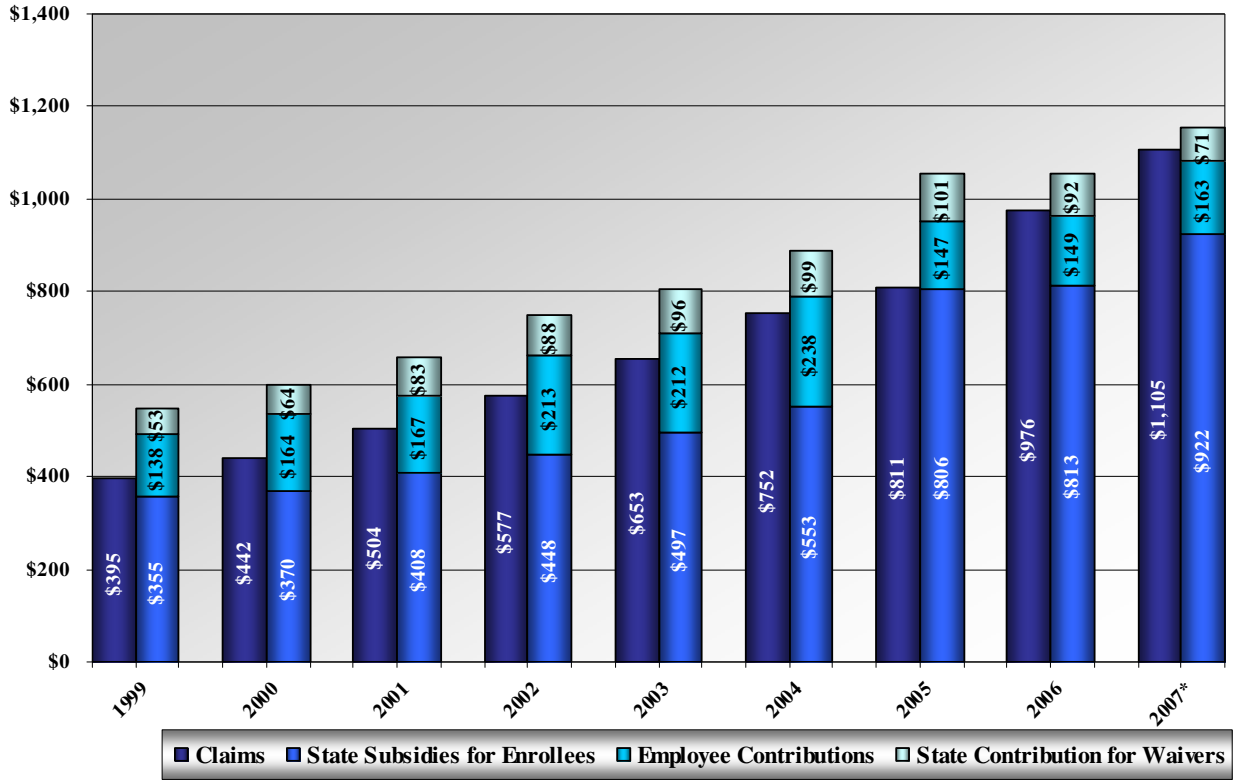
In 2006 the Commonwealth's average monthly contribution to health insurance was expected to increase to $512.71 based on total employer contribution of $565,833,612.28 from January-July. The $511 noted above reflects the actual average monthly contribution year-to-date in 2007.

## PEHI/KEHP Program Aggregate Costs, 1999 to 2006

The total dollars in health insurance incurred claims paid by the insurers covering members of the PEHI Program in 1999 through 2005 and by the Commonwealth's self-funded program in 2006 and 2007 are identified in the "Claims" bars in Exhibit II. For 2007 the annual claims have been estimated based on the 2007 experience year to date, projected to the end of the year.

Also shown are the contributions made by the Commonwealth into the healthcare FSAs for employees who have waived coverage through 2006, and into health reimbursement arrangements (HRAs) in 2007.

***Exhibit II***
**Historical Annual PEHI/KEHP Program Claims and Net Commonwealth Costs ($Millions)**




*Source:* *Claims reported by the Commonwealth's insurers and administrators and compiled by MedStat and enrollment reported by the Commonwealth. Employee Contributions for 1999 through 2005 provided by the Commonwealth.*

* *2007 figures reflect estimates based on January through June 2007 claims experience, projected to year end.*

Exhibit II includes the amounts the Commonwealth expended in subsidies in 1999 through 2007 (estimated) for all members of the PEHI/KEHP Program. The section of each bar labeled "State Subsidies for Enrollees" reflects the amounts subsidized by the Commonwealth for those individuals who elected health insurance through the PEHI/KEHP program. The lighter section at the top of this bar identifies the Commonwealth's contribution to healthcare FSAs through 2006, HRA in 2007, for all eligible individuals who waived health insurance through the PEHI/KEHP program.

In 2006 the Commonwealth's subsidies represented 84.5% of total costs (97.1% for Single Coverage, 69.7% blended for the employee + dependent coverage tiers). This compares as follows to 2006 national averages for the government sector (2007 comparison is also included):

| | 2006 | | 2007 | |
|---|---|---|---|---|
| | Kaiser | KEHP | Kaiser | KEHP |
| **Employee Only** | 94.0% | 97.1% | 87.0% | 97.2% |
| **Employee + Dependents** | 82.0% | 69.7% | 78.0% | 71.5% |
| **Overall** | 90.2% | 84.5% | 84.1% | 85.0% |

*Source: Benchmark s from 2006 and 2007 Kaiser Family Foundation Employer Health Benefits surveys.*

The amounts shown as the Commonwealth's subsidies include the portion of the PEHI/KEHP program premiums paid by all of the employers and retirement systems for individuals eligible to participate in the Program. ***These amounts assume that all participating groups apply the same employer subsidy policy as applies to state and school district employees***.

Finally, all retirees are assumed to receive the maximum subsidy amount applicable to non-hazardous duty retirees.

Employee contribution rates for 2006 did not change from 2005; contribution rates for 2007 increased from 2006 levels. Exhibit III provides a table of monthly employee contribution rates for 2006 and 2007 by plan option, coverage tier, and non-smoker versus smoker status. The previous estimate of the Commonwealth's subsidy in 2006 and 2007 was based on total costs incurred offset by these employee contributions.

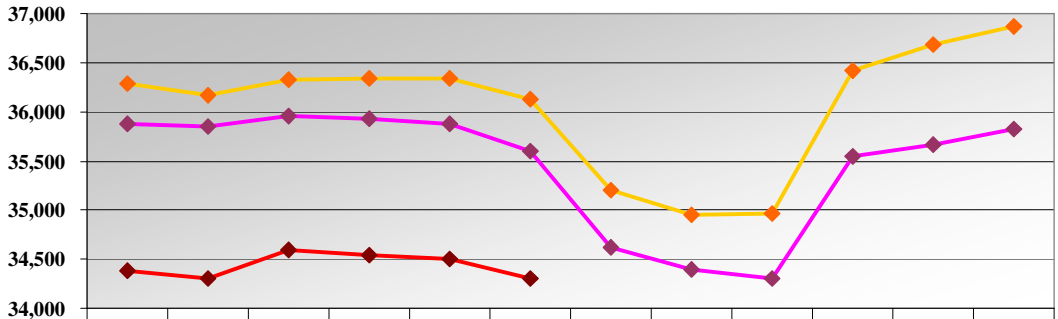
***Exhibit III***
**2005 through 2007 Monthly Employee Contribution Rates**

| | Monthly Employee Contribution Rates | | | | |
|---|---|---|---|---|---|
| | Single | Couple | Parent Plus | Family | Cross Ref |
| ***2006 Rates*** | | | | | |
| **Essential Plan:** | | | | | |
| **Non-Smoker** | | $259.52 | $55.00 | $320.14 | $0.00 |
| **Smoker** | | $289.52 | $85.00 | $350.14 | $15.00 |
| **Enhanced Plan:** | | | | | |
| **Non-Smoker** | $0.00 | $357.72 | $114.00 | $429.24 | $9.72 |
| **Smoker** | $15.00 | $387.72 | $144.00 | $459.24 | $24.72 |
| **Premier Plan:** | | | | | |
| **Non-Smoker** | $18.20 | $398.66 | $170.38 | $474.74 | $33.08 |
| **Smoker** | $33.20 | $428.66 | $200.38 | $504.74 | $48.08 |
| ***2007 Rates*** | | | | | |
| **Essential Plan:** | | | | | |
| **Non-Smoker** | | $274.90 | $58.26 | $339.12 | $0.00 |
| **Smoker** | | $306.68 | $90.04 | $370.90 | $15.88 |
| **Enhanced Plan:** | | | | | |
| **Non-Smoker** | $0.00 | $378.92 | $120.76 | $454.72 | $10.30 |
| **Smoker** | $15.88 | $410.70 | $152.54 | $486.50 | $26.18 |
| **Premier Plan:** | | | | | |
| **Non-Smoker** | $19.28 | $422.30 | $180.48 | $502.90 | $35.04 |
| **Smoker** | $35.16 | $454.08 | $212.26 | $534.68 | $50.92 |
| **Select Plan:** | | | | | |
| **Non-Smoker** | $0.00 | $285.54 | $92.88 | $341.58 | $7.74 |
| **Smoker** | $12.50 | $309.48 | $117.32 | $365.46 | $19.66 |

The Commonwealth provides employees who waive coverage with a deposit into their healthcare FSA/HRA to be used to pay for healthcare expenses incurred out-of-pocket. For 2005 this monthly amount was $234; for 2006 the $234 amount was maintained for the months January through June, and then decreased to $200 per month for the remainder of 2006; for 2007, the amount decreased to $175 per month. Exhibit IV shows the monthly waiver participation for the period January 2005 through June 2007. 2005 exhibited significant waiver participation seasonality month to month, a pattern that repeated for 2006 and appears to be repeating in 2007 as well. Though the waiver amount has dropped from $234 in 2005 to $175 in 2007, over 34,000 employees continue to waive coverage and take the HRA contribution.

The Commonwealth's contribution to the FSAs/HRAs of individuals who waived health insurance also includes forfeitures from these accounts. Actual end of year forfeitures resulting from the FSA "use it or lose it" rule represent an offset to this cost, and have historically equaled approximately 5% of the total amount shown as the state contribution for waivers in Exhibit II.

***Exhibit IV***
**2005 through June 2007 Monthly Coverage Waiver Participation**




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Waivers 2005 | 36,292 | 36,170 | 36,325 | 36,334 | 36,343 | 36,123 | 35,204 | 34,946 | 34,966 | 36,422 | 36,684 | 36,866 |
| Monthly Change 2005 | | -0.3% | 0.4% | 0.0% | 0.0% | -0.6% | -2.5% | -0.7% | 0.1% | 4.2% | 0.7% | 0.5% |
| Waivers 2006 | 35,873 | 35,844 | 35,955 | 35,927 | 35,874 | 35,602 | 34,625 | 34,399 | 34,305 | 35,548 | 35,671 | 35,818 |
| Monthly Change 2006 | -2.7% | -0.1% | 0.3% | -0.1% | -0.1% | -0.8% | -2.7% | -0.7% | -0.3% | 3.6% | 0.3% | 0.4% |
| Waivers 2007 | 34,378 | 34,299 | 34,595 | 34,547 | 34,499 | 34,303 | | | | | | |
| Monthly Change 2007 | -4.0% | -0.2% | 0.9% | -0.1% | -0.1% | -0.6% | | | | | | |

*Source: Commonwealth's enrollment data.*

## THE COMMONWEALTH HEALTH INSURANCE PROGRAM

### An Examination of 2006 Experience

This section of the report provides a summary of the trends identified from claims and enrollment data submitted by the insurance carriers providing health insurance coverage to those participating in the Commonwealth's Public Employee Health Insurance (PEHI) Program prior to 2006. The 2006-2007 information is based on self-insured claims reported by the administrators. This summary of relevant information and trends is based on health benefits data for the Commonwealth compiled by MedStat. Note that the analysis below does not reflect fully-insured premiums, but actual claims experience incurred within the health plans offered by the Commonwealth.

The plan name was changed in 2006 to the Kentucky Employee Health Plan (KEHP).

### A Note about 2007 and 2006 Claims Experience

Claims for medical and pharmacy services and supplies received by KEHP members in 2006 as shown in this report differ from that shown in prior years' reports due to the fact that this year's report includes complete 2006 data (defined as claims incurred in 2006 and paid through June 2007; claims incurred in 2006 but not yet paid as of the end of June 2007 have been estimated).

Claims for medical and pharmacy services and supplies received by PEHI/KEHP Program members in 2006 that were not paid as of June 30, 2007 (i.e., incurred but not reported claims, or IBNR claims) have been actuarially estimated and included as part of this report.

At the time of the writing of this report, 2007 claims data were available through June 2007. Calendar year 2007 claims experience was estimated by applying the claims seasonality observed in 2006 to the six months of claims experience available in 2007. These are the data used in Exhibit II. "Seasonality" refers to variations in claims payments over the course of a year resulting from the timing of meeting deductibles (lower levels of claims early in the year) and maximum out-of-pocket limits (higher levels of claims later in the year).

Throughout this report, unless otherwise noted, references to "claims" reflects incurred claims (both paid and not yet paid), rather than just claims paid.

## Medical & Pharmacy Trends for 2006

**Key Findings & Considerations**

The key findings and considerations from our Medical and Pharmacy Analysis from 2005 to 2006 are as follows:

- The aggregate percentage increase (or "trend") in medical and pharmacy claims costs from 2004 to 2006 (inclusive of estimated IBNR) was 13% (total claims cost increase, both member and Commonwealth's). The increase per member per month was 12%.
- The aggregate percentage increase (or "trend") in medical and pharmacy claims costs from 2005 to 2006 (inclusive of estimated IBNR) was 20% (total claims cost increase, both member and Commonwealth's). The per member per month (PMPM) increase for time period was 17%
- Non-Medicare eligible retirees' medical costs are approximately 1.7 times that of active employees while their pharmacy costs are approximately 2 times that of active employees. However, their rate of increase is lower than the active group.
- The distribution of the Commonwealth's medical and pharmacy claim costs by place of service has remained constant from 2005 to 2006.
- Utilization, by place of service (hospital, physician, etc.) remained relatively consistent from 2005 to 2006.
- Pharmacy claims in 2006 grew to almost 24% of the overall KEHP claims.

Additional facts and figures in support of these findings, along with additional analysis, are provided in the sections below.

### Detailed Findings - Medical and Pharmacy Trends

As a whole, the Commonwealth's health insurance administrators issued payments to medical providers (excluding pharmacies) of approximately $976.0 million in calendar year 2006 for services received by KEHP members. This represents an aggregate increase of 20.4% (17.2% per member per month) over calendar year 2005, which—in turn—followed an aggregate 7.8% increase from 2004 to 2005, and an aggregate 15.2% increase from 2003 to 2004. The aggregate increase differs from the PMPM increase because it includes cost increases due to the increased number of members covered by the program.

Payments for the KEHP pharmacy benefits increased by 29.7% in aggregate (26.3% per member per month) from $182.1 million in 2005, to $236.1 million in 2006. The increase from 2004 to 2005 was 8.3%, and the increase from 2003 to 2004 was 15.8%. These year-to-year cost increases for medical and pharmacy benefits are summarized below in Exhibit V.

***Exhibit V***
**2004 – 2006 Claims Experience**

| | Public Employee Health Insurance Program Historic Experience | | | | | |
|---|---|---|---|---|---|---|
| | 2004 | % Change | 2005 | % Change | 2006 | % Change |
| ***Aggregate*** | | | | | | |
| Medical Claims | $584,015,270 | 15.1% | $628,574,865 | 7.6% | $739,747,177 | 17.7% |
| Rx Claims | $168,061,796 | 15.8% | $182,071,346 | 8.3% | $236,119,319 | 29.7% |
| Total Claims | $752,077,066 | 15.2% | $810,646,211 | 7.8% | $975,866,496 | 20.4% |
| Premiums Paid | $740,994,630 | 6.7% | $952,279,912 | 28.5% | | |
| Covered Lives | 227,917 | 0.7% | 229,867 | 0.9% | 236,038 | 2.7% |
| ***Per Member Per Month*** | | | | | | |
| Medical Claims | $214 | 14.3% | $228 | 6.5% | $261 | 14.6% |
| Rx Claims | $61 | 15.0% | $66 | 8.2% | $83 | 26.3% |
| Total Claims | $275 | 14.5% | $294 | 6.9% | $345 | 17.2% |
| Premiums Paid | $271 | 6.0% | $345 | 27.4% | $409 | 18.4% |
| Loss Ratio | 101.5% | | 85.1% | | 84.3% | |

*Source: Claims and premiums reported by the Commonwealth's insurers and administrators and enrollment reported by the Department for Employee Insurance compiled by MedStat. 2006 "Premiums Paid" represent self-insured premium equivalent rates (expected 2006 incurred claims plus administrative fees).*

The table above includes the fully-insured "Claims Loss Ratio" for 2004 and 2005. For 2004 and 2005, this measure reflects the ratio of incurred claims over fully-insured premiums paid. The measure under the self-insured arrangement for 2006 reflects the ratio of incurred claims over premium equivalent rates. In each case, administrative fees are excluded from the loss ratios for 2004, 2005, and 2006. For 2006, when provided at the plan option level, the self-insured plan claims loss ratios are:

- Essential Plan: 39.4%
- Enhanced Plan: 67.7%
- Premier Plan: 101.0%
- All Plans Combined: 84.3%

The average annual trend experienced by the Commonwealth on a PMPM basis from 2004 to 2006 was 11.9% (10.5% for medical, 16.9% for prescription drugs). The trend measurement is based on annual change in the PMPM claims, and has not been adjusted for (a) changes in insurers and underlying networks and discount rates, (b) changes in plan design provisions, and (c) changes in underlying demographics such as selection by option and/or coverage tier. In short, the percentage change figures presented here are measures of how the underlying incurred and paid claims have increased for the Commonwealth from 2004 through 2006.

By comparison, participants in Segal Company's 2007 *Health Plan Cost Trend Survey* recently reported projected 2006 experience in an update to previously published projections. The projected aggregate medical and pharmacy cost benchmark increases nationwide for 2006 were 11.6% for PPO medical expenditures and 11.9% for pharmacy costs.

Because pharmacy expenditures have increased in general at a higher rate than other healthcare expenses over the last six years, pharmacy service expenditures have grown as a percentage of the Commonwealth's total healthcare expenditures from 21.4% in 2002, to 22.2% in 2003, to 22.3% in 2004, to 22.5% in 2005, and to 24.2% in 2006.

Total healthcare claims (medical and pharmacy) increased in aggregate by 20.4% from 2005 to 2006. This followed an increase of 7.8% from 2004 to 2005, and 15.2% from 2003 to 2004. In 2006, these expenditures totaled approximately $976 million.

**2006 Transition to Self Insurance**

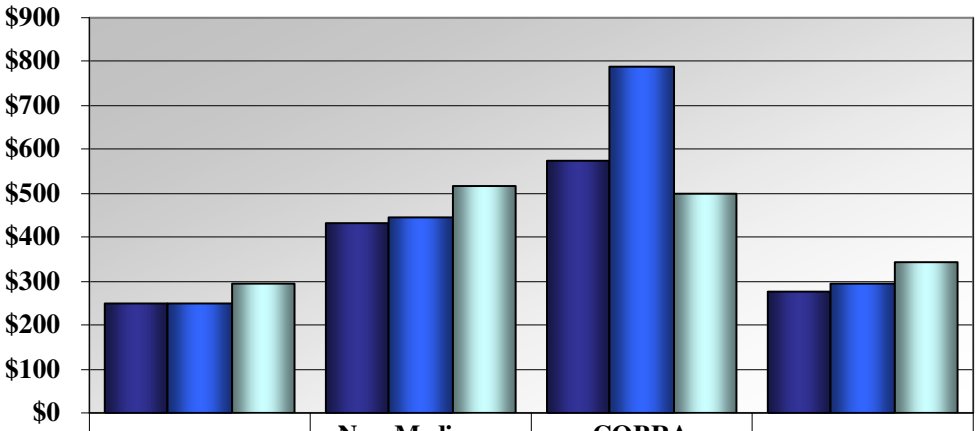
In 2006 the Commonwealth began self-insuring the health benefits program. Therefore, the premium equivalent rates for this year reflect the cost of claims, administration or other services, without any margin for insurance company risk. This change in the funding arrangement is transparent to members as it has no impact on plan design. It is designed to only change the funding approach by the Commonwealth, and benefits the Commonwealth by (1) removing insurance premium profit and margin, (2) permitting greater flexibility in plan design, and (3) more closely relating costs to claims activity.

**Claims Payment by Type of Enrollee**

As noted above, PMPM medical and pharmacy claims increased in total from 2005 to 2006 by 20.4%. Exhibits VI, VII, and VIII provide similar summaries of the PMPM cost increases for 2004 through 2006 for actives, non-Medicare eligible retirees, and COBRA continuees. Medical and pharmacy combined are in Exhibit VI, medical only (Exhibit VII), and pharmacy only (Exhibit VIII). Total medical and pharmacy claims for both non-Medicare eligible retirees and COBRA continuees in 2006 were approximately 1.7 times higher than those of active employees.

The overall cost increase is segmented by the categories of participants including active employees and non-Medicare eligible retirees (COBRA participants are also included, however the number of COBRA participants is too small to impact the overall averages). Between 2004 and 2005, as well as several years prior to 2004, there has been a gradual migration from the active employee group to the non-Medicare eligible retiree group. The 20.4% increase in aggregate claims from 2005 to 2006 is impacted by the aging of the covered population. This issue will be discussed in more detail later.

***Exhibit VI* Paid Per Member**
**Total Medical and Pharmacy Claims Per Month (PMPM)**



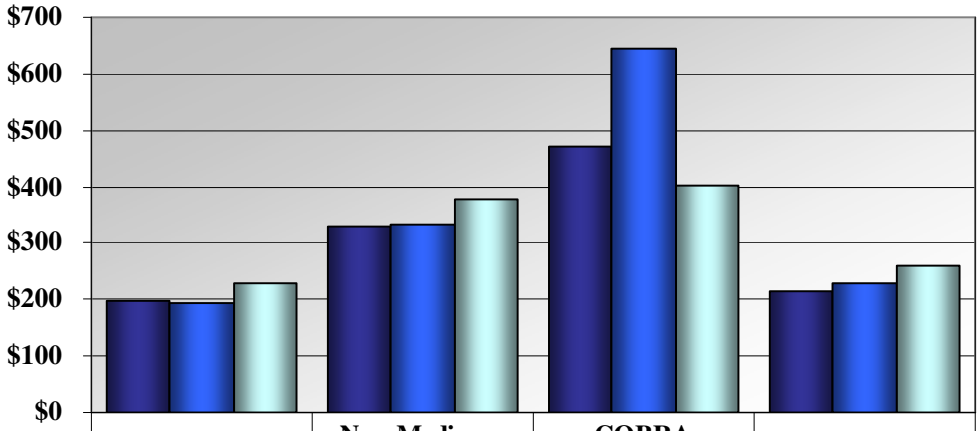

| | Active Full-Time | Non-Medicare Eligible Retiree | COBRA Continuee | Total |
|---|---|---|---|---|
| 2004 | $247 | $434 | $575 | $275 |
| 2005 | $248 | $445 | $788 | $294 |
| 2006 | $296 | $517 | $497 | $345 |
| Increase 2004 to 2005 | 0.1% | 2.5% | 37.1% | 6.9% |
| Increase 2005 to 2006 | 19.5% | 16.4% | -36.9% | 17.2% |

| | | | | |
|---|---|---|---|---|
| 2006 Member Counts: | 182,783 | 52,667 | 481 | 235,931 |
| 2006 Total Claims: | $646,933,925 | $326,070,567 | $2,862,004 | $975,866,496 |

*Source: Claims reported by the Commonwealth's insurers and administrators and enrollment reported by the Department for Employee Insurance compiled by MedStat*

The average medical claims only PMPM change (Exhibit VII) from 2005 to 2006 was 17.2% for the active employee group, and 13.1% for the non-Medicare eligible retiree group. Non-Medicare eligible retiree medical and COBRA medical claims in 2006 were approximately 1.7 and 1.8 times that of the active employees, respectively.

***Exhibit VII***
**Medical Claims Paid Per Member Per Month**



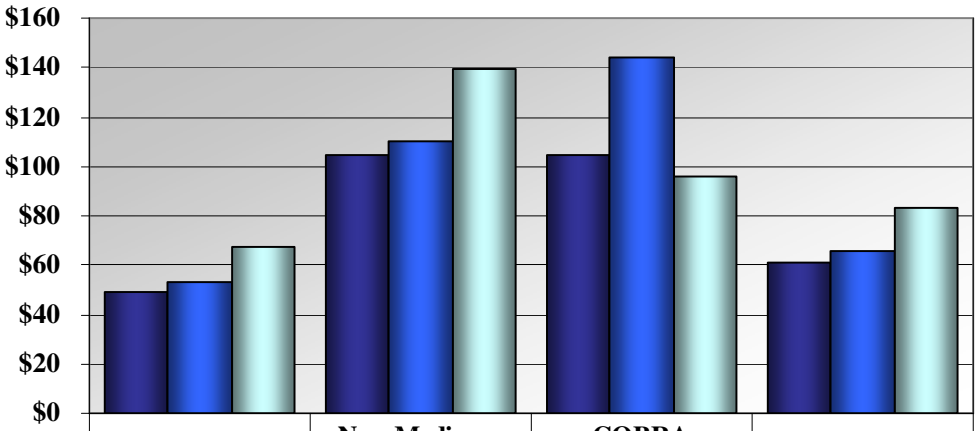

| | Active Full-Time | Non-Medicare Eligible Retiree | COBRA Continuee | Total |
|---|---|---|---|---|
| 2004 | $198 | $329 | $470 | $214 |
| 2005 | $195 | $334 | $644 | $228 |
| 2006 | $228 | $378 | $401 | $261 |
| Increase 2004 to 2005 | -1.6% | 1.6% | 37.0% | 6.5% |
| Increase 2005 to 2006 | 17.2% | 13.1% | -37.7% | 14.6% |

| | | | | |
|---|---|---|---|---|
| 2006 Member Counts: | 182,783 | 52,667 | 481 | 235,931 |
| 2006 Total Claims: | $499,125,280 | $238,310,860 | $2,311,037 | $739,747,177 |

*Source: Claims reported by the Commonwealth's insurers and administrators and enrollment reported by the Department for Employee Insurance compiled by MedStat.*

Similarly, when looking at pharmacy claims only (Exhibit VIII), the average PMPM change from 2005 to 2006 for each of the active employee and non-Medicare eligible retiree groups increased by 28.0% and 26.2%, respectively. Non-Medicare eligible retiree pharmacy and COBRA pharmacy claims in 2006 were approximately 2.1 and 1.4 times that of the active employees, respectively.

***Exhibit VIII***
**Pharmacy Claims Paid Per Member Per Month**




| | Active Full-Time | Non-Medicare Eligible Retiree | COBRA Continuee | Total |
|---|---|---|---|---|
| 2004 | $49 | $105 | $105 | $61 |
| 2005 | $53 | $110 | $145 | $66 |
| 2006 | $68 | $139 | $96 | $83 |
| Increase 2004 to 2005 | 6.9% | 5.4% | 37.8% | 8.2% |
| Increase 2005 to 2006 | 28.0% | 26.2% | -33.7% | 26.3% |

| | | | | |
|---|---|---|---|---|
| 2006 Member Counts: | 182,783 | 52,667 | 481 | 235,931 |
| 2006 Total Claims: | $147,819,182 | $87,748,998 | $551,138 | $236,119,319 |

*Source: Claims reported by the Commonwealth's insurers and enrollment reported by the Department for Employee Insurance compiled by MedStat.*

## Claims By Place of Service

The distribution of claims by place of service appears consistent in each category. While there appears to be a increase in Outpatient hospital ER services and a decrease in Outpatient Hospital Non-ER services, a comparison to earlier numbers should be avoided. Prior to 2006 the Commonwealth had multiple insured medical vendors. During that time, MedStat indicates that 40% or more of revenue codes for emergency room and outpatient hospital services were missing from the facility claims data submitted (45% for Humana, 60% CHA). In 2006 when Humana became the sole medical administrator, the percent of missing codes dropped to zero. Thus the improved reporting of the revenue codes is the driver for at least some of the identified increased emergency room and outpatient hospital costs shown between 2005 and 2006.

Exhibit IX shows the paid claims distribution by provider place of service. This distribution has remained consistent from 2005 to 2006.

***Exhibit IX***
**Claims Distribution by Place of Service**

| | Public Employee Health Insurance Program Historic Experience Split by Place of Service | | | |
|---|---|---|---|---|
| | 2005 | % of Total | 2006 | % of Total |
| ***Paid Claims*** | | | | |
| Inpatient Hospital | $189,557,128 | 23.4% | $220,215,591 | 22.6% |
| Outpatient Hospital - ER | $24,047,093 | 3.0% | $42,517,050 | 4.4% |
| Outpatient Hospital - Non-ER | $213,506,424 | 26.3% | $242,576,477 | 24.9% |
| Other Facility (e.g. SNF, Hospice, ESRD) | $5,668,050 | 0.7% | $1,150,876 | 0.1% |
| Professional - Office | $155,300,703 | 19.2% | $183,274,884 | 18.8% |
| All Other | $40,495,467 | 5.0% | $50,012,299 | 5.1% |
| Prescription Drugs | $182,071,346 | 22.5% | $236,119,319 | 24.2% |
| **Total Claims** | **$810,646,211** | | **$975,866,496** | |

*Source: Commonwealth's claims data aggregated by MedStat; adjusted for incurred but not reported claims.*

## Enrollment/Demographic Analysis

**Key Findings & Considerations**

The key findings and considerations from the Enrollment and Demographic Analysis from 2005 to 2007 (estimate based on the first 6 months of 2007) are as follows:

- The total KEHP enrollment has grown by nearly 3%.
- On average, the 2006 population is younger than the 2005 population. This trend toward lower average age seems to be continuing in 2007 and is most likely driven by an increase in coverage for dependent children.
- The percentage of enrollees electing employee only coverage has decreased, with an increase in employee plus spouse and family coverage
- The ratio of the number of dependents enrolled to the number of employees enrolled has been consistent from 2004 to 2007.
- It has been noted in the past that some Medicare eligible plan participants (dependents of non-Medicare eligible retirees) do not have Medicare as their primary coverage *("primary" coverage refers to the plan that pays first, with secondary coverage only paying after the primary plan has paid)*, and that the KEHP coverage is being used as the primary insurance in those instances. As the proportion of non-Medicare eligible retirees grows (and with them, presumably, Medicare eligible dependents) there will be an added cost impact due to the KEHP plans being used as the primary coverage.
- While non-Medicare eligible retirees accounted for 22.3% of plan membership in 2006, they account for:
  - 32% of medical costs
  - 37% of pharmacy costs
  - 33% of total healthcare costs
- Plan options and the employee contribution levels were revised for 2005. Employee contributions did not change between 2005 and 2006. Additionally, the select plan option was offered for the first time in 2006.
- 2006 employee contributions were frozen at the 2005 level. This may have influenced an increase in dependent enrollment. This trend seems to be continuing in 2007.
- From 2005 to 2007, there is a slight decrease each year in enrollment in the Premier plan, with enrollment migrating to the Enhanced and Select plan.

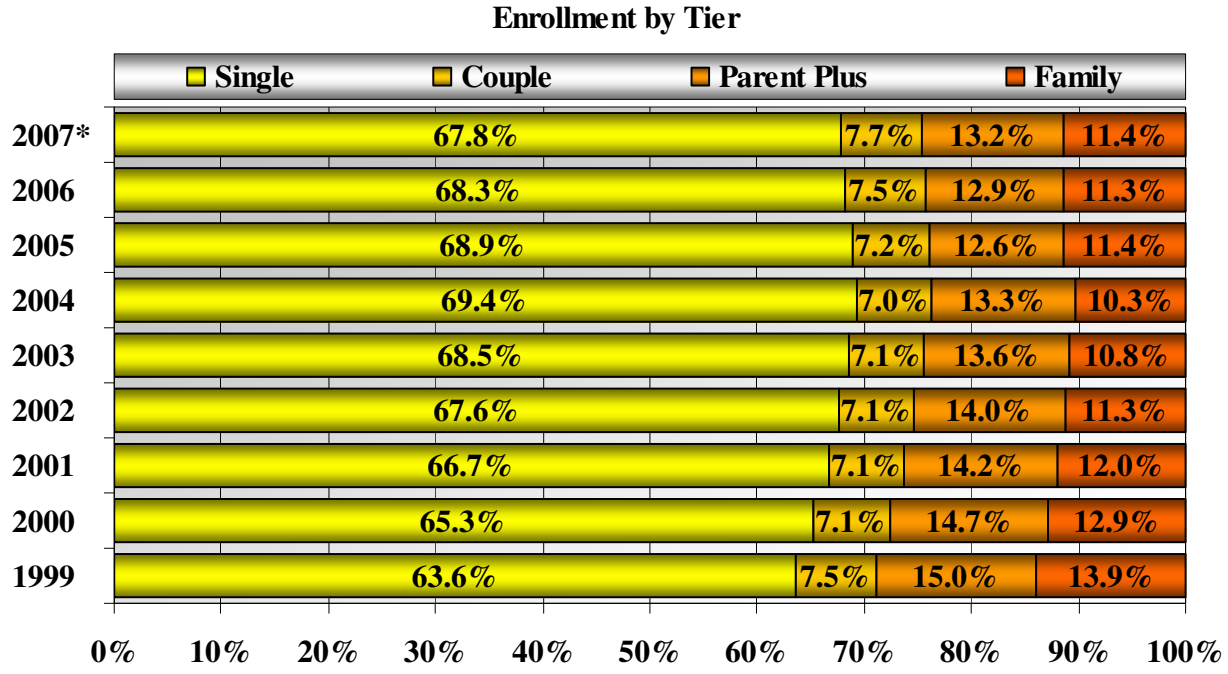
Additional facts and figures in support of these findings, along with some additional analysis, are provided in the section below.

**Detailed Findings - Enrollment/Demographic Analysis**

The number of employees / non-Medicare eligible retirees in the KEHP Program electing health insurance increased from about 137,024 in 2001 to 143,920 in 2004, 143,911 in 2005, and 146,703 in 2006, and 150,343 in 2007 (year to date average for 2007). As illustrated in Exhibit X, in 2005, for the first time since 1999, the percentage of plan enrollees who elected employee only coverage declined slightly, while the percentage of enrollees electing couple coverage increased slightly and the percentage electing employee plus family coverage increased by a percentage point, a shift from the patterns seen over the last 6 years. Enrollment in 2006 and 2007 continues the shift, with fewer employees electing single coverage and more employees electing couple and parent plus coverage. Changes in the pattern are likely the result of:

- The impact of the Commonwealth's historical subsidy structure – the Commonwealth paid the full cost of single coverage under the lowest cost option provided, the Enhanced Plan (the Essential Plan is not available for single only coverage), but did not directly subsidize any portion of the cost of dependent health insurance coverage;
- The frozen contributions in 2006 versus 2005 contributed to the slight shift into coverage tiers with dependents (Parent Plus and Family); and
- A continuing increase in the number of retirees covered under the Program contributed to the shift from the single and parent plus coverage to couple coverage.

***Exhibit X***
**Enrollment By Coverage Tier**




*Source: Commonwealth's enrollment reported by the Department for Employee Insurance and aggregated by MedStat.*

The shift in enrollment seen in 2006 can most likely be attributed to the shift in subsidy strategy for dependents. The Commonwealth, in 2005, provided a richer dependent subsidy than was provided in 2004. This may have caused a shift from single coverage to couple coverage, and from parent plus to family coverage.

## Group Composition

The group composition in the KEHP Program has changed very little between 2005 and 2007. The initial 2007 numbers indicate that there is an overall 3% increase in covered members over 2006. The increase in retirees from 2006 to 2007 was 2.8%, less than the 4.4% retiree growth from 2005 to 2006. The increase in actives from 2006 to 2007 was 2.7%, compared to 2.2% for actives from 2005 to 2006. While retirees and their covered dependents comprised 14.3% of the total insured KEHP Program in 1999, by the end of June 2007 they comprised 22.3% of the group.

***Exhibit XI***
**Average Number of Covered Members By Group**

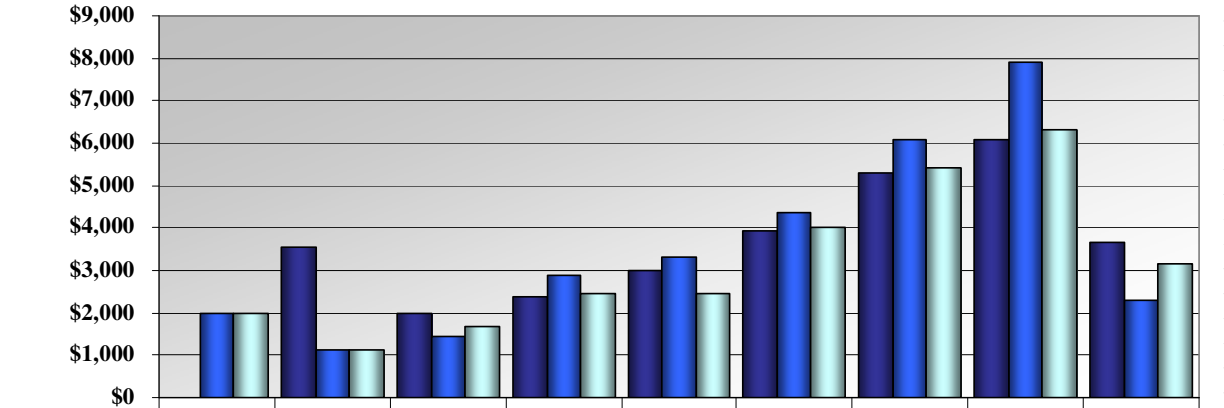
| | Average Covered Members by Group (Includes Dependents) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2005 | | | 2006 | | | 2007 (6 Months) | | |
| | Average Lives | % of Total | % Change | Average Lives | % of Total | % Change | Average Lives | % of Total | % Change |
| ***By Covered Group*** | | | | | | | | | |
| **State Employees** | 52,372 | 22.8% | -1.7% | 52,805 | 22.4% | 0.8% | 52,484 | 21.6% | -0.6% |
| **School Boards** | 112,148 | 48.8% | 0.3% | 115,944 | 49.1% | 3.4% | 120,759 | 49.8% | 4.2% |
| **Health Departments** | 4,049 | 1.8% | 0.1% | 4,045 | 1.7% | -0.1% | 4,153 | 1.7% | 2.7% |
| **KRS** | 31,419 | 13.7% | 8.8% | 33,281 | 14.1% | 5.9% | 34,808 | 14.4% | 4.6% |
| **KTRS** | 19,007 | 8.3% | 4.1% | 19,386 | 8.2% | 2.0% | 19,337 | 8.0% | -0.3% |
| **KCTCS** | 4,529 | 2.0% | 7.8% | 4,960 | 2.1% | 9.5% | 5,172 | 2.1% | 4.3% |
| **Quasi/Local Govt** | 5,674 | 2.5% | -6.2% | 5,030 | 2.1% | -11.4% | 5,241 | 2.2% | 4.2% |
| **COBRA** | 673 | 0.3% | -49.8% | 481 | 0.2% | -28.5% | 609 | 0.3% | 26.6% |
| **Sub-total** | **229,870** | | 0.6% | **235,931** | | 2.6% | **242,563** | | 2.8% |
| ***By Covered Status*** | | | | | | | | | |
| **Actives** | 178,771 | 77.8% | -0.4% | 182,783 | 77.5% | 2.2% | 187,809 | 77.4% | 2.7% |
| **Retirees** | 50,425 | 21.9% | -0.4% | 52,667 | 22.3% | 4.4% | 54,145 | 22.3% | 2.8% |
| **COBRA** | 673 | 0.3% | -49.8% | 481 | 0.2% | -28.5% | 609 | 0.3% | 26.6% |
| **Sub-total** | **229,870** | | 0.9% | **235,931** | | 2.6% | **242,563** | | 2.8% |
| **Unknown/Missing** | 0 | | | 107 | | | 466 | | |
| **Grand Total** | **229,870** | | 0.9% | **236,038** | | 2.7% | **243,029** | | 3.0% |

*Source: Commonwealth's enrollment data aggregated by MedStat.*

Due to the impact that age has on an individual's healthcare costs this increase in retiree membership has significant cost implications for the Commonwealth's KEHP Program. As illustrated in Exhibit XII, the average annual 2006 healthcare claims expenses incurred by someone in the Commonwealth's program whose age was between 60 and 64 ($5,409) was over three times that of someone between the ages of 20 and 29 ($1,690). The results illustrated in Exhibit XII reflect averages for all members in each age group, inclusive of those who incurred no claims.

***Exhibit XII***

**2006 Demographics—Employee and Dependent Member Medical Claims by Age**




| | <10 | 10 to 19 | 20 to 29 | 30 to 39 | 40 to 49 | 50 to 59 | 60 to 64 | 65 to 74 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Employees | | $3,549 | $2,003 | $2,368 | $3,009 | $3,928 | $5,292 | $6,083 | $3,652 |
| Dependents | $1,999 | $1,115 | $1,445 | $2,877 | $3,320 | $4,344 | $6,088 | $7,915 | $2,300 |
| All | $1,999 | $1,117 | $1,690 | $2,447 | $2,447 | $4,000 | $5,409 | $6,321 | $3,141 |

**Member Counts:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Employees | | 27 | 11,445 | 24,482 | 31,415 | 48,464 | 22,568 | 8,302 | 146,703 |
| Dependents | 19,307 | 28,589 | 14,543 | 4,537 | 7,207 | 10,020 | 3,886 | 1,244 | 89,335 |
| Total | 19,307 | 28,616 | 25,989 | 29,019 | 38,622 | 58,484 | 26,454 | 9,547 | 236,038 |

**Aggregate Claims ($Millions):**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Employees | | $0.1 | $22.9 | $57.8 | $94.3 | $190.0 | $119.2 | $50.4 | $534.7 |
| Dependents | $38.5 | $31.8 | $21.0 | $13.0 | $23.9 | $43.4 | $23.6 | $9.8 | $205.1 |
| Total | $38.5 | $31.9 | $43.8 | $70.9 | $118.2 | $233.4 | $142.8 | $60.2 | $739.7 |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat*

From 2005 to 2006, the average employee age decreased from 47.7 to 46.9. Further, the average member age dropped from 38.8 to 37.8. This trend toward lower average age seems to be continuing in 2007 and is most likely driven by an increased coverage of dependent children. The higher than average proportion of female adults covered by the Program also contributes to the overall costs. Exhibit XIII shows the gender mix and average ages for the Commonwealth membership over the 2005, 2006, and 2007 years.

***Exhibit XIII***
**Population Demographics—Key Statistics**

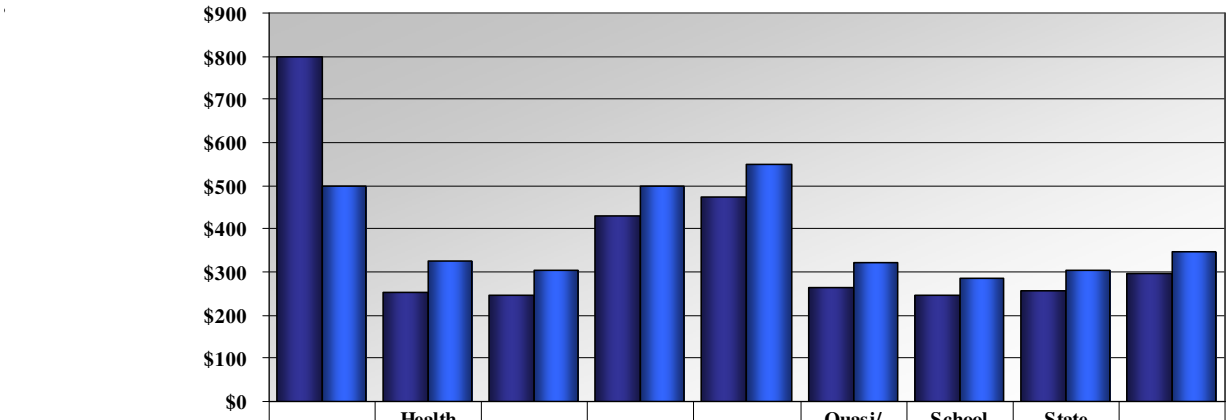
| Actives, Non-Medicare Eligible Retirees, and COBRA Participants | Commonwealth | | |
|---|---|---|---|
| | 2005 | 2006 | 2007 |
| Average Employee Age | 47.7 | 46.9 | 46.2 |
| Average Member Age | 38.8 | 37.8 | 37.0 |
| Employee Percentage Male | 35.3% | 35.2% | 35.0% |
| Member to Employee Ratio | 1.6 | 1.6 | 1.6 |
| % of Covered Members Who Are: | | | |
| Adult Male | 27.2% | 27.1% | 27.0% |
| Adult Female | 46.9% | 46.8% | 46.7% |
| Children | 25.9% | 26.1% | 26.3% |

*Source: Commonwealth's enrollment data aggregated by MedStat.*

While the Kentucky Community and Technical College System (KCTCS) is still not a significant percentage of the total group that participates in the KEHP Program, the number of KCTCS covered individuals continues to increase. When KCTCS was formed as an entity separate from the University of Kentucky (UK), individuals in this group were given the option of remaining in the UK benefits plan or joining the KEHP Program. Individuals hired after this separation have only been eligible to join the KEHP Program. Therefore, between 1999 and the end of June 2007, this group has grown from 2,340 covered lives to 5,172.

Exhibits XIV, XV, and XVI illustrate the per member per month costs for medical plus pharmacy, medical only, and pharmacy only, respectively, for the various covered groups in 2005 and 2006.

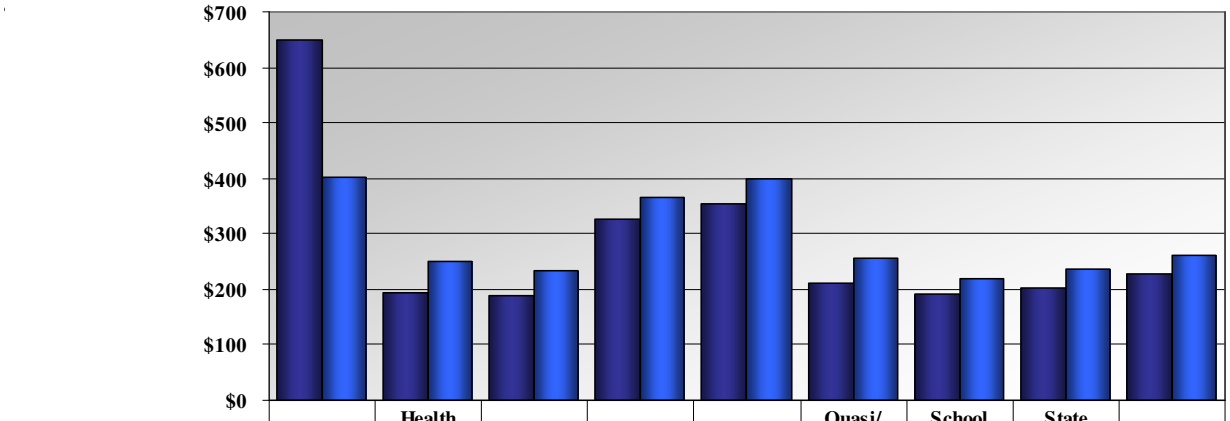
***Exhibit XIV***
**Medical and Pharmacy Claims Paid Per Member Per Month—Covered Groups**




| | COBRA | Health Depts. | KCTCS | KRS | KTRS | Quasi/ Local | School Boards | State Employee | Total |
|---|---|---|---|---|---|---|---|---|---|
| 2005 Paid PMPM | $799.40 | $253.62 | $246.99 | $431.13 | $473.01 | $262.90 | $244.53 | $255.35 | $294.94 |
| 2006 Paid PMPM | $497.08 | $324.20 | $304.94 | $497.74 | $551.11 | $320.92 | $285.72 | $304.02 | $345.63 |
| % Change 2005 to 2006 | -37.8% | 27.8% | 23.5% | 15.5% | 16.5% | 22.1% | 16.8% | 19.1% | 17.2% |
| 2006 Members | 481 | 4,045 | 4,960 | 33,281 | 19,386 | 5,030 | 115,944 | 52,805 | 235,931 |
| 2006 Claims ($Millions) | $2.9 | $15.8 | $18.2 | $199.3 | $128.5 | $19.4 | $398.6 | $193.2 | $975.9 |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat.*

*Exhibit XV*
**Medical Claims Paid Per Member Per Month—Covered Groups**

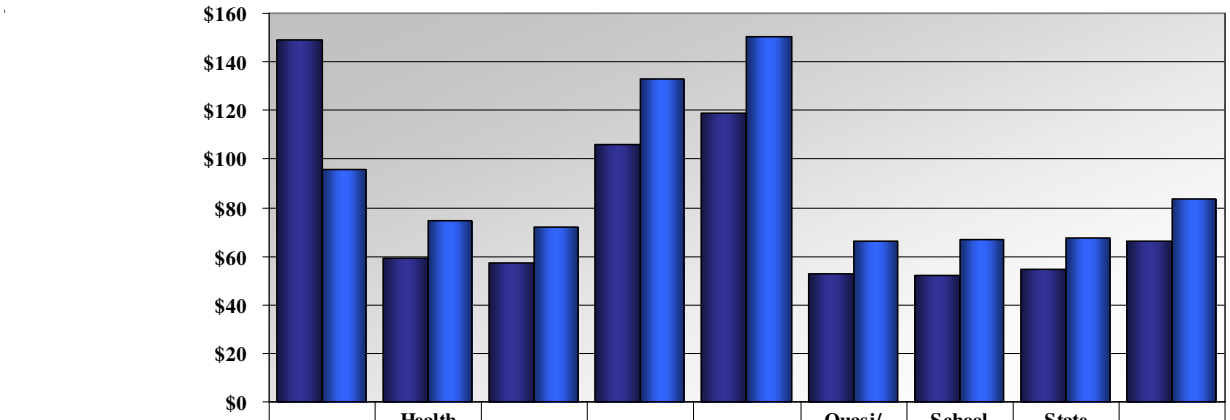



| | COBRA | Health Depts. | KCTCS | KRS | KTRS | Quasi/ Local | School Boards | State Employee | Total |
|---|---|---|---|---|---|---|---|---|---|
| 2005 Paid PMPM | $650.64 | $194.75 | $189.56 | $325.30 | $353.83 | $210.18 | $192.52 | $201.05 | $227.88 |
| 2006 Paid PMPM | $401.24 | $249.67 | $233.18 | $364.85 | $400.58 | $254.69 | $219.12 | $236.49 | $261.17 |
| % Change 2005 to 2006 | -38.3% | 28.2% | 23.0% | 12.2% | 13.2% | 21.2% | 13.8% | 17.6% | 14.6% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2006 Members | 481 | 4,045 | 4,960 | 33,281 | 19,386 | 5,030 | 115,944 | 52,805 | 235,931 |
| 2006 Claims ($Millions) | $2.3 | $12.2 | $13.9 | $146.2 | $93.5 | $15.4 | $305.9 | $150.4 | $739.7 |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat.*

*Exhibit XVI*
**Pharmacy Claims Paid Per Member Per Month—Covered Groups**



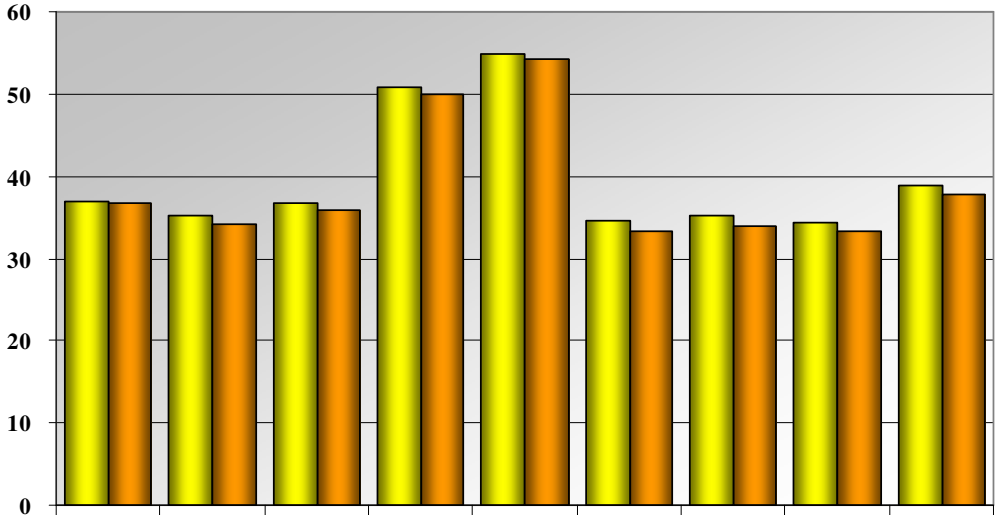

| | COBRA | Health Depts. | KCTCS | KRS | KTRS | Quasi/ Local | School Boards | State Employee | Total |
|---|---|---|---|---|---|---|---|---|---|
| 2005 Paid PMPM | $148.76 | $58.87 | $57.43 | $105.82 | $119.18 | $52.72 | $52.01 | $54.30 | $66.01 |
| 2006 Paid PMPM | $95.84 | $74.54 | $71.76 | $132.89 | $150.54 | $66.23 | $66.60 | $67.53 | $83.36 |
| % Change 2005 to 2006 | -35.6% | 26.6% | 24.9% | 25.6% | 26.3% | 25.6% | 28.1% | 24.4% | 26.3% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2006 Members | 481 | 4,045 | 4,960 | 33,281 | 19,386 | 5,030 | 115,944 | 52,805 | 235,931 |
| 2006 Claims ($Millions) | $0.6 | $3.6 | $4.3 | $53.1 | $35.0 | $4.0 | $92.7 | $42.8 | $236.1 |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat.*

Exhibit XVII provides, for each coverage group, the average ages of the members in 2005 and 2006. In general the average ages for members has not appreciably changed from 2005 to 2006.

***Exhibit XVII***
**2005 and 2006 Average Member Age—By Group**




| | COBRA | Health Depts. | KCTCS | KRS | KTRS | Quasi/ Local | School Boards | State Employee | Total |
|---|---|---|---|---|---|---|---|---|---|
| 2005 Avg Member Age | 36.9 | 35.3 | 36.6 | 50.9 | 54.9 | 34.7 | 35.2 | 34.5 | 38.8 |
| 2006 Avg Member Age | 36.7 | 34.3 | 35.9 | 49.9 | 54.3 | 33.4 | 34.0 | 33.3 | 37.8 |

*Source: Commonwealth's enrollment data aggregated by MedStat.*

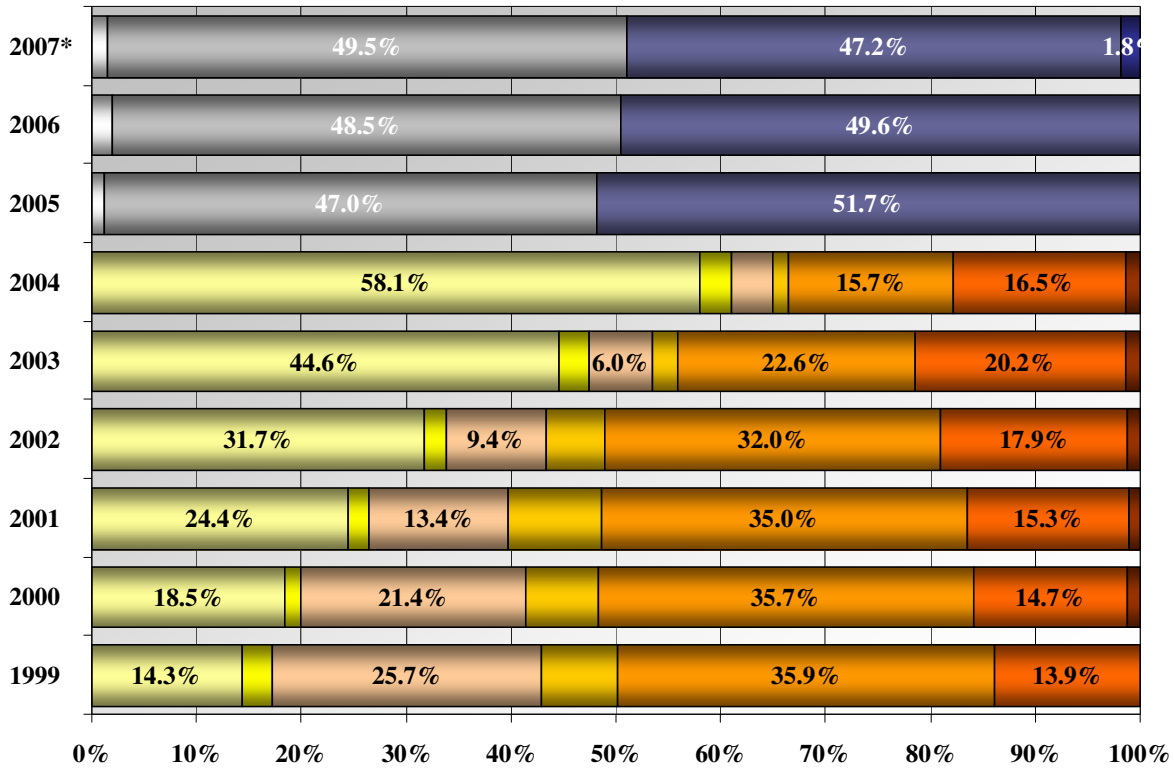
The impact of these demographic drivers on expected healthcare costs per employee are as follows:

- Employee Coverage Status: From 2005-2007, active employees as a portion of covered members has decreased from 77.8% to 77.4%, while retirees have increased from 21.9% to 22.3%. The higher cost of retirees and the gradually increasing proportion of retirees to actives will add costs as this trend continues in the coming years.
- Average Employee Age and Gender of Covered Adults: The average age of employees enrolled in the Program in 2006 was 46.9 (decrease from average of 47.7 for 2005). For the Commonwealth, based on the age distribution and the proportion of non-Medicare eligible retirees covered, costs increase about 3.6% on average per year of age. Based on the change in average age from 2005 to 2006, from an actuarial benchmark basis, total costs would decrease approximately 3.1% due solely to the change in the age distribution. The KEHP's actual claims experience, however, includes the impact of healthcare inflation (unit price and mix of services provided) and the growing proportion of retirees.

## Enrollment by Option

The KEHP Program's enrollment by plan/option from 1999 through the first quarter of 2007 is illustrated below in Exhibit XVIII.

***Exhibit XVIII***
**1999 - 2007 Enrollment By Plan Option**




| | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007* |
|---|---|---|---|---|---|---|---|---|---|
| Select | | | | | | | | | 1.8% |
| Premier | | | | | | | 51.7% | 49.6% | 47.2% |
| Enhanced | | | | | | | 47.0% | 48.5% | 49.5% |
| Essential | | | | | | | 1.2% | 1.9% | 1.5% |
| EPO | 0.0% | 1.2% | 1.1% | 1.2% | 1.3% | 1.4% | | | |
| HMO B | 13.9% | 14.7% | 15.3% | 17.9% | 20.2% | 16.5% | | | |
| HMO A | 35.9% | 35.7% | 35.0% | 32.0% | 22.6% | 15.7% | | | |
| POS B | 7.3% | 7.0% | 8.8% | 5.6% | 2.4% | 1.5% | | | |
| POS A | 25.7% | 21.4% | 13.4% | 9.4% | 6.0% | 3.9% | | | |
| PPO B | 2.9% | 1.5% | 2.0% | 2.2% | 2.9% | 2.9% | | | |
| PPO A | 14.3% | 18.5% | 24.4% | 31.7% | 44.6% | 58.1% | | | |

*Source: Commonwealth's enrollment aggregated by MedStat.*
** January through June 2007 data only.*

From 2005 to 2006, Premier membership declined slightly from 51.7% to 49.6% and this trend continues for the first half of 2007;

In 2007, the Select plan, a consumer driven design, was introduced, and nearly 2% of members moved into this plan.

## Large Claims Analysis

**Key Findings & Considerations**

The key findings and considerations from the Large Claims Analysis from 2005 and 2006 are as follows:

- While only 0.8% of members had claims totaling over $50,000 in 2006, these members consumed 20% of the Commonwealth's total paid claims expense for 2006.
- Approximately 19% of the population is generating approximately 73% of the medical and drug claims costs.
- The KEHP Program's large claim experience for 2006 corresponds closely to the expected number of claimants at the various actuarial benchmark claims levels.
- The KEHP Program's large claim experience is in line with benchmarks. However, the proportion of low users ($0 to $1,000 in claims) is substantially lower than expected. Note that the benchmark figures reflect submitted claims while the Commonwealth experience reflects paid claims. This difference would produce the most dramatic difference is actual versus benchmark measurement for the 2 smallest dollar claims bands, but would not impact the comparison above $5,000 in claims.
- The top three major diagnostic categories are consistent with 2005 and include musculoskeletal, circulatory and digestive.

Additional facts and figures in support of these findings, along with some additional analysis, are provided in the section below. Note that the 2006 benchmarks have not been adjusted to match the age, sex, and adult/child ratio characteristics of the Commonwealth's population. The benchmarks shown are based on PricewaterhouseCoopers' normative claims distribution data encompassing eight million lives.

*Exhibit XIX*
**Large Claim Analysis—2005 and 2006 Claim Payments Stratified by Claim Amount.**

| Range of Benefit Payments | 2005 Actual | | | 2006 Actual | | | 2006 Benchmarks | |
|---|---|---|---|---|---|---|---|---|
| | Members | % of Members | % of Claims | Members | % of Members | % of Claims | Members | % of Members |
| $0 - $1,000 | 113,925 | 49.6% | 4.4% | 99,084 | 42.0% | 4.0% | 135,591 | 57.4% |
| $1,000 - $2,000 | 35,364 | 15.4% | 6.3% | 40,821 | 17.3% | 6.0% | 32,789 | 13.9% |
| $2,000 - $5,000 | 43,002 | 18.7% | 16.9% | 50,857 | 21.5% | 16.7% | 28,936 | 12.3% |
| $5,000 - $10,000 | 21,344 | 9.3% | 18.3% | 25,474 | 10.8% | 18.1% | 16,379 | 6.9% |
| $10,000 - $20,000 | 9,872 | 4.3% | 16.6% | 11,938 | 5.1% | 16.7% | 11,325 | 4.8% |
| $20,000 - $50,000 | 4,741 | 2.1% | 17.4% | 5,927 | 2.5% | 18.0% | 8,517 | 3.6% |
| $50,000 - $100,000 | 1,140 | 0.5% | 9.5% | 1,367 | 0.6% | 9.6% | 1,800 | 0.8% |
| $100,000 - $200,000 | 367 | 0.2% | 6.1% | 423 | 0.2% | 5.8% | 454 | 0.2% |
| $200,000 - $300,000 | 66 | 0.03% | 1.9% | 93 | 0.04% | 2.3% | 112 | 0.05% |
| $300,000 - $400,000 | 24 | 0.01% | 1.0% | 27 | 0.01% | 0.9% | 62 | 0.03% |
| $400,000 - $500,000 | 9 | 0.004% | 0.5% | 15 | 0.01% | 0.7% | 27 | 0.01% |
| $500,000 - $750,000 | 12 | 0.005% | 0.9% | 8 | 0.003% | 0.5% | 30 | 0.01% |
| $750,000 - $1,000,000 | 0 | 0.0000% | 0.0% | 1 | 0.0004% | 0.1% | 5 | 0.002% |
| $1,000,000 - $2,000,000 | 1 | 0.0004% | 0.1% | 2 | 0.0008% | 0.3% | 11 | 0.005% |
| Over $2,000,000 | 0 | 0.0000% | 0.0% | 1 | 0.0004% | 0.3% | 1 | 0.0004% |
| **Total** | **229,867** | **100.0%** | **100.0%** | **236,038** | **100.0%** | **100.0%** | **236,038** | **100.0%** |

**Commonwealth 2005 PEHI Plan experience less than benchmark (# of members in payment range)**
**Commonwealth 2005 PEHI Plan experience more than benchmark (# of members in payment range)**

*Source: Commonwealth's enrollment and medical and prescription drug claims data aggregated by MedStat.*

## Detailed Findings - Large Claims Analysis (Medical and Prescription Drug Claims)

In 2006, approximately 19% of members incurred paid medical and prescription drug claims over $5,000. The associated benefits for these members amount to 78.1% of claims paid in 2006. Members with paid claims over $50,000 comprise only 0.8% of all members, but their benefit costs account for 20.4% of the claims paid in 2006. Compared against actuarial benchmarks of large claims distributions (medical and prescription drugs), the Commonwealth experience above $20,000 is better than the expected distribution.

*Exhibit XX*
**2006 Distribution by "User-Type"**

| | | Low Users $0 - $1,000 | Medium Users $1,000 - $5,000 | High Users $5,000 - $100,000 | Very High Users >$100,000 |
|---|---|---|---|---|---|
| **Commonwealth 2006 Net Payments** | **% Payments** | **3.5%** | **18.4%** | **64.4%** | **13.7%** |
| | **% Members** | **42.1%** | **38.8%** | **18.9%** | **0.2%** |
| **2006 Paid Claims Benchmarks** | **% Members** | **57.4%** | **26.2%** | **16.1%** | **0.3%** |
| **Difference** | **% Members** | **-15.3%** | **12.6%** | **2.8%** | **-0.1%** |

*Source: Benchmark paid claims per MedStat comparative national data (all industries).*

Similarly, when compared against actuarial norms by "user type," the Commonwealth's incidence of catastrophic claims (defined as claims in excess of $100,000) is comparable to norms. The percentage of low volume users is below actuarial norms.

## Diagnosis & Wellness Issues

**Key Findings & Considerations**

The key findings and considerations regarding diagnosis & wellness issues from 2005 to 2006 are as follows:

- A high proportion of costs are incurred for treatment of participants with diagnoses that fall into a short list of major diagnostic categories. This list has remained constant from 2004 to 2006. This indicates that disease management efforts should continue to be targeted to the primary diagnosis categories of circulatory (e.g. heart and stroke), musculoskeletal (e.g. lower back), and respiratory (e.g. asthma and pulmonary disease).
- In 2006, ActiveHealth identified 40,199, or 16.8% of KEHP members with at least one chronic condition that could be managed through the ICM program. During the year, 6% of KEHP members received program and disease information either via mail or telephonically with a nurse. 3,595 are receiving scheduled phone calls from a nurse.
- KEHP members have generally not met wellness screening targets.
- The Commonwealth's overall population, of which the KEHP membership is a significant component, continues to exhibit serious population health issues, including preterm births, obesity, adult diabetes, smoking, lack of physical activity, and deaths due to heart attack and stroke. These health risks can be improved through behavioral change.

## Detailed Findings - Diagnosis & Wellness Issues

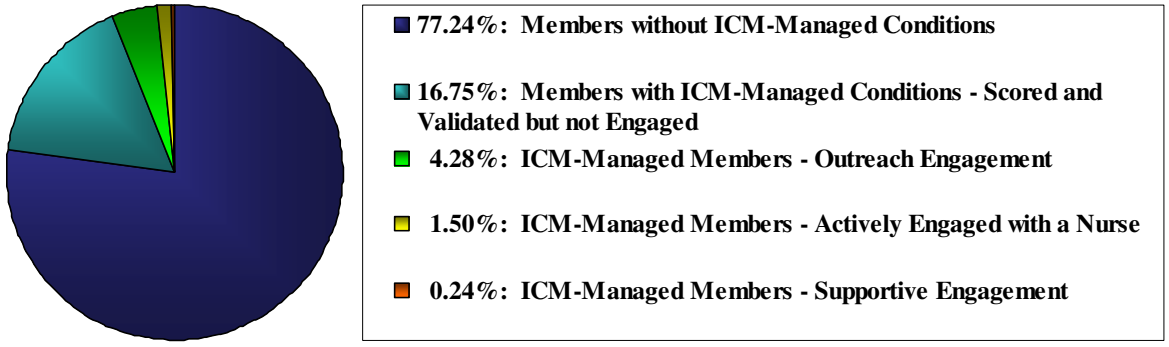
### Informed Care Management Program

The Commonwealth's KEHP program includes an offering from ActiveHealth Management and Humana, called Informed Care Management (ICM) that provides disease management to members who have one or more of 31 identified chronic conditions. 40,199, or 16.8%, of KEHP members were identified with at least one of these chronic conditions in 2006 by ActiveHealth.

14,446, or 4.3%, of the Kentucky Employees Health Plan members have received outreach from the ICM program either via mail or telephonically with a nurse.

3,595, or 1.5%, of the Kentucky Employees Health Plan members are in contact with a nurse on a scheduled basis.

***Exhibit XXI***
***ICM Activity***

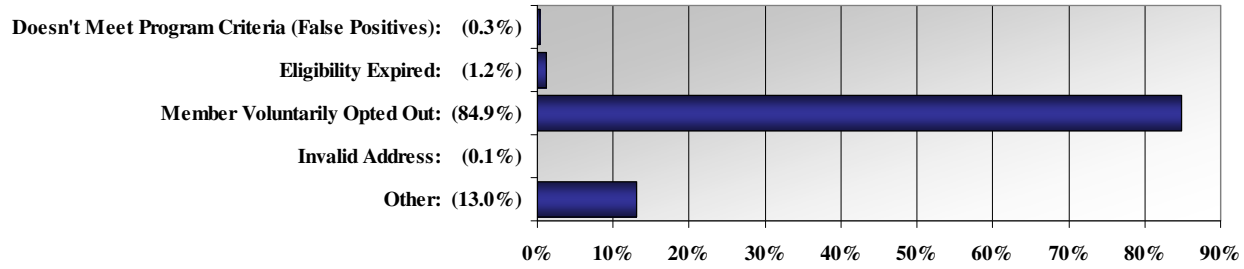



*Source: Commonwealth's participation data reported by ActiveHealth Management for the period January through December 2006.*

Participation at all levels has increased significantly throughout the year, from a total of 4,144 in the first quarter to 14,446 in the fourth quarter. For a disease management program to produce optimal results for an average population, at least 10% of a covered population should be receiving outreach and between 2 and 3% should be actively engaged with a nurse. Approximately 4% of KEHP members received outreach but haven't engaged with a nurse and 1.5% were actively involved with a nurse. Further, given the age and health issues of this population, a higher outreach target may be more appropriate.

A total of 5,360 individuals left the ICM Program in 2006. Of these, 84.9% voluntarily opted out of the program, 3,952 because they were not interested in the program, 484 because they manage their condition with their physicians and 119 because they were too busy to participate. Other reasons for discharge are specified in Exhibit XXII

***Exhibit XXII***
***ICM Discharges***




*Source: Commonwealth's participation data reported by ActiveHealth Management for the period January through December 2006.*

The conditions being addressed by the ICM program are highlighted in Exhibit XXIII(a). The top five conditions, based on number of identified cases, are adult diabetes, hypertension, coronary artery disease (CAD), gastroesophogeal reflux (GERD), and adult asthma. In 2006, ActiveHealth identified 14,446 members with one or more diagnoses that could be managed through the ICM program. Over 50% of the members identified in the ICM population have adult diabetes as one of their conditions to be addressed in their ICM engagement whether or not it is the "primary" condition for their engagement. Over 32% of members identified for ICM have hypertension. Often, members in a disease management program have co-morbidities, or multiple conditions that can exacerbate each other, that are addressed together during the member's engagement in a program.

***Exhibit XXIII(a)***
***ICM Total Engaged Population***

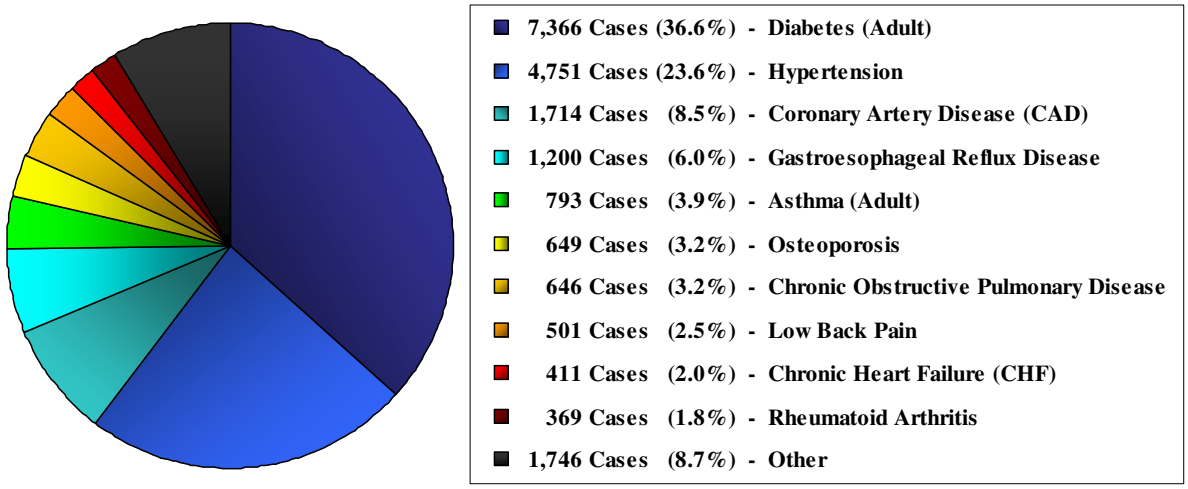
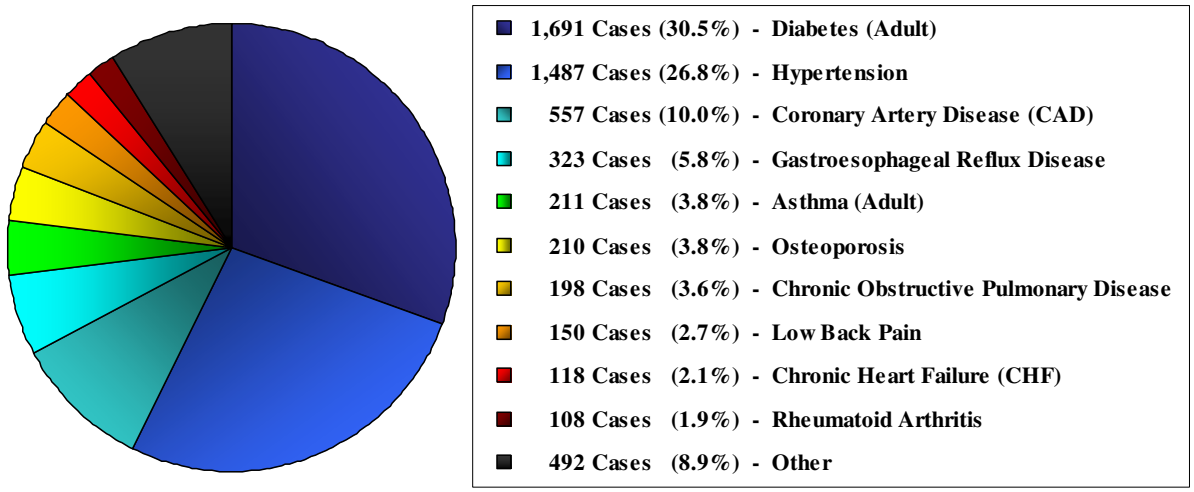


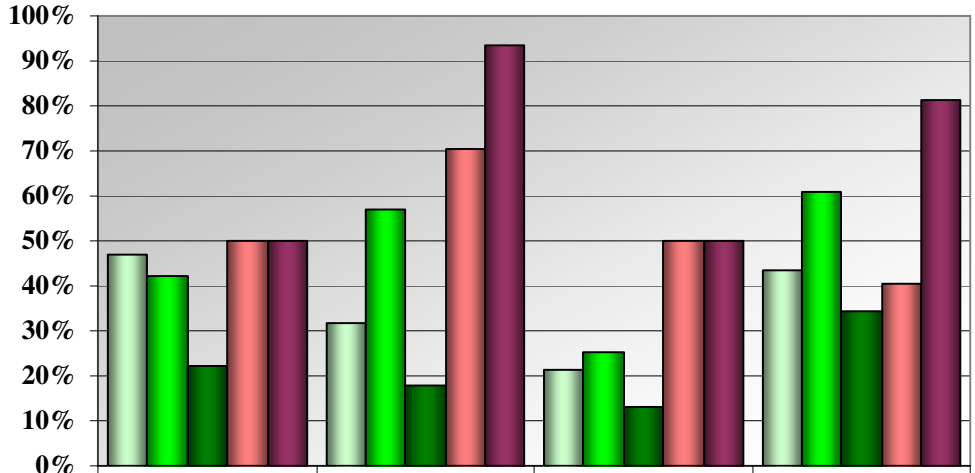
Exhibit XXIII(b) provides insight on the members who are engaged in the ICM program through nursing interventions. In this group, identified members are participating in scheduled calls with nurses to discuss their conditions and receive education and assistance in dealing with those conditions. As with the total engaged population, the nurse engaged population has a high prevalence of adult diabetes, hypertension, CAD, GERD and adult asthma. Nearly a third of those engaged with a nurse have adult diabetes and over a quarter have hypertension.

***Exhibit XXIII(b)***
***ICM Nurse Engaged Population***




*Source: Commonwealth's participation data reported by ActiveHealth Management for the period January through December 2006.*

*Exhibit XXIV(a)*
**2006 Wellness Screening Utilization**




| | Cervical* | Mammograms* | Colon | Cholesterol |
|---|---|---|---|---|
| Active Full-Time | 47% | 32% | 21% | 44% |
| Early Retiree | 42% | 57% | 25% | 61% |
| COBRA | 22% | 18% | 13% | 35% |
| Target Rate (Actives) | 50% | 70% | 50% | 40% |
| Target Rate (Retirees) | 50% | 94% | 50% | 81% |

| Age Guidelines | Women 18-64 | Women 40-69 | All Ages 50+ | 35-65M, 45-65F |
|---|---|---|---|---|
| Frequency Guidelines | Every 2 Years | 40-49: 2 Years<br>50+: Annually | Every 2 Years | 35-49: 5 Years<br>50+: Annually |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat.*

Screening rates are compared to "Healthy People 2010" and other industry accepted targets. In cases where the frequency guidelines vary by age, the targets have been adjusted to reflect the actual KEHP age distribution (evident with the different targets for the actives versus the early retirees for mammograms and cholesterol screenings). "Healthy People 2010" is a set of national health objectives to achieve over the first decade of the new century. Created by scientists both inside and outside of Government, it identifies a wide range of public health priorities and specific, measurable objectives. It can be used by many different people, states, communities, and others to develop health improvement programs.

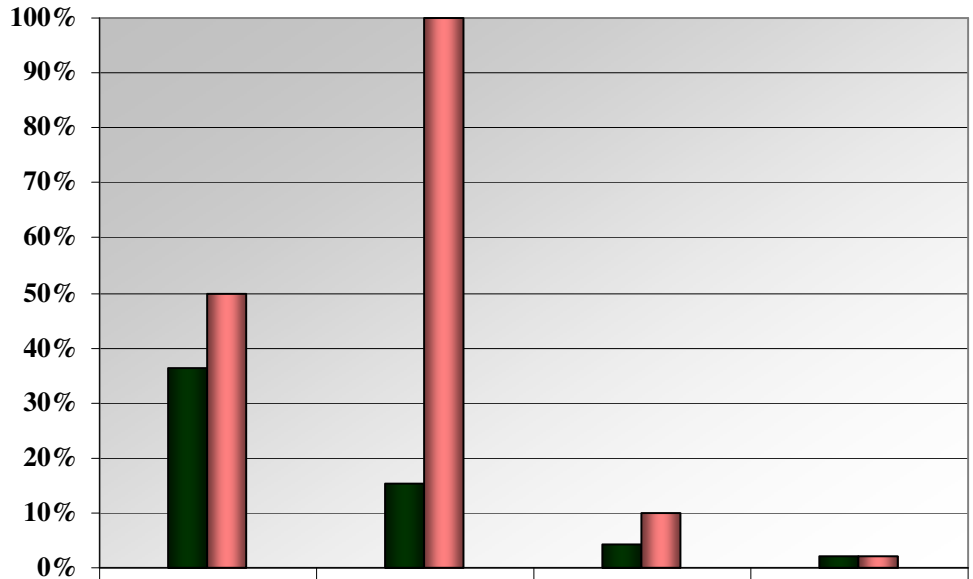
"Healthy People 2010" is built upon initiatives that began over 20 years ago. The 1979 Surgeon General's Report, "Healthy People" and "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" served as the basis for state and community plans. Like its predecessors, Healthy People 2010 was developed through a broad consultation process, based on scientific knowledge and designed to measure programs over time.

"Healthy People 2010" is designed to achieve two primary goals:

- Goal 1: Increase Quality and Years of Healthy Life
- Goal 2: Eliminate Health Disparities

For early retirees, there was a drop in utilization of wellness screenings in 2006 compared against 2005 for cervical, mammograms and cholesterol, with 18 percentage points difference for mammograms and 32 percentage points for cholesterol. For active adults there was a drop in 2006 of 11 percentage points for cervical cancer screenings, of 5 percentage points in mammograms and a 31 percentage point drop in cholesterol screenings. For both populations, colon screenings jumped significantly from 2005 to 2006.

***Exhibit XXIV(b)***
**2006 Wellness Screening Utilization**




| | PSA | Influenza Vaccine | Tetanus/ Diphtheria | Measles, Mumps, Rubella |
|---|---|---|---|---|
| All | 36% | 15% | 4% | 2% |
| Target Rate (All) | 50% | 100% | 10% | 2% |

| Age Guidelines | Men 50+ | All Ages 18+ | All Ages 50+ | All Ages 18+ |
|---|---|---|---|---|
| Frequency Guidelines | Every 1-2 Years | Annually | Every 10 Years | Once In Adulthood |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat.*

## Population Health Indicators

The Kaiser Family Foundation has tabulated, state by state, the prevalence of certain health behaviors and indicators that adversely affect the health of individuals. These behaviors and indicators correlate closely to health status. Many plan sponsors are focusing efforts on improving the overall health of their covered population, as measured by these indicators, in order to promote a healthy workforce. The exhibits that follow provide several such correlations using data compiled by the Kaiser Family Foundation. Note that the data provided here are state-wide population information, and not reflective of the KEHP program or its members.

Additionally, the Health Management Research Center (HMRC) at the University of Michigan has conducted studies over the last 20 years on the financial relationship between lifestyle characteristics and health status and healthcare costs. Lifestyle characteristics that have been shown contribute to higher healthcare claims are shown in Exhibit XXV.

***Exhibit XXV***
**Health Risks and Behaviors**

| Health Risk Measure | High Risk Criteria |
|---|---|
| Alcohol | More than 14 drinks/week |
| Blood Pressure | Systolic >139 mmHg or Diastolic >89 mmHg |
| Body Weight | Body mass index (BMI) at or more than 27.5% |
| Cholesterol | Greater than 239 mg/dl |
| Existing Medical Problem | Heart, Cancer, Diabetes, Stroke |
| HDL | Less than 35 mg/dl |
| Illness Days | >5 days last year |
| Life Satisfaction | Partly or not satisfied |
| Perception of Health | Fair or poor |
| Physical Activity | Less than one time/week |
| Safety Belt Usage | Using safety belt less than 100% of time |
| Smoking | Current smoker |
| Stress | High |

*Source: University of Michigan Health Management Research Center study.*

The HMRC studies defined "Low Risk" individuals as people who have 2 or less of the above high risks, "Medium Risk" individuals as those with 3 or 4 of the above risks, and "High Risk" individuals as those with 5 or more of the above risks. On average, Medium Risk individuals incur healthcare claims at 1½ times the level of Low Risk individuals. High Risk individuals incur healthcare claims at over 2½ times the level of Low Risk individuals.

To the extent that a benefit plan provides programs focused on long term behavior change and incentives for people to address the above high risk behaviors, savings resulting from improved health status can be realized by the benefit plan. Some of the exhibits that follow focus on four of the above health risk measures: body weight, existing medical problem, physical activity, and smoking (shown in red in Exhibit XXV). In addition, data regarding pre-natal care and birth outcomes are included as this is an additional health indicator that is relevant to the measurement of health and healthy behaviors in a population.

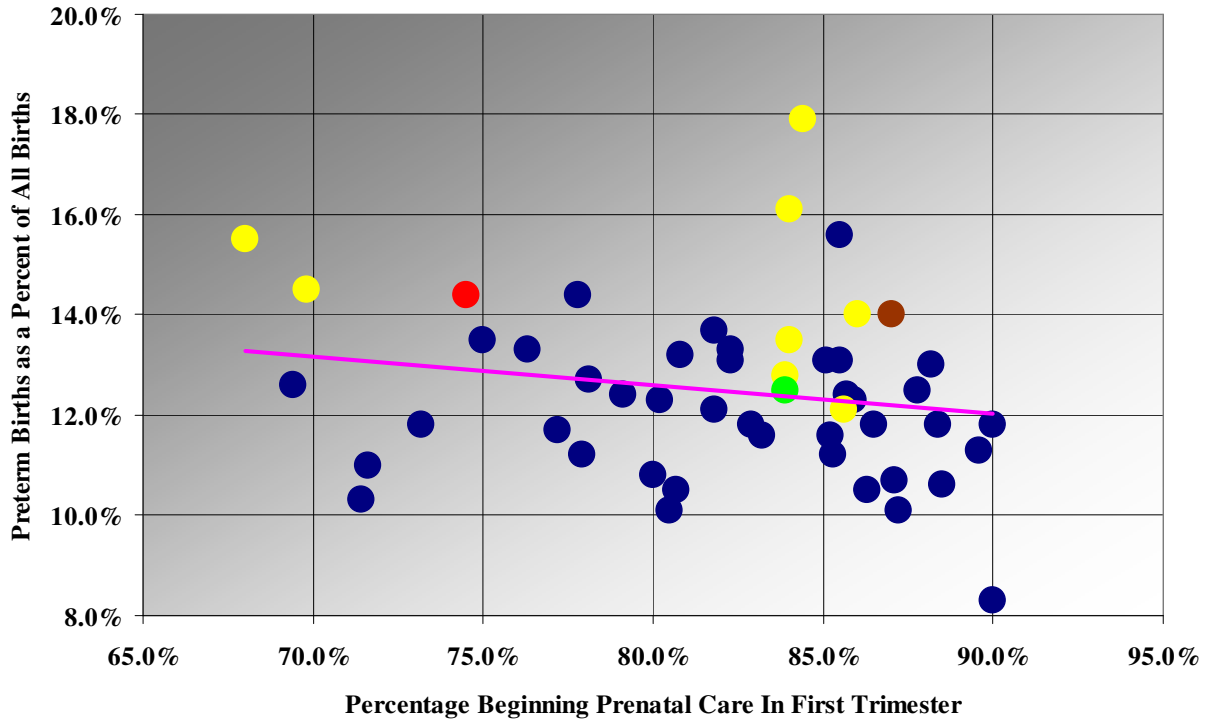
The following is included in each exhibit:

- Kentucky: Shown in Red.
- Kentucky (Prior Year): Shown in Brown. In cases where the state data has been updated since last year, the comparable metric from last year's report is shown.
- Neighboring States: Shown in Yellow. Consists of Alabama, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.
- All Other States: Shown in Blue.
- US National Average: Shown in Green.

For each chart in the exhibit a correlation line has been included to illustrate the approximate correlation between the two factors shown on each chart.

A more detailed table follows each chart in the exhibit providing the Kentucky, Neighboring State, and US National Average measures for the lifestyle and health status metrics.

*Exhibit XXVI*
**Correlation Between First Trimester Prenatal Care and Preterm Births**

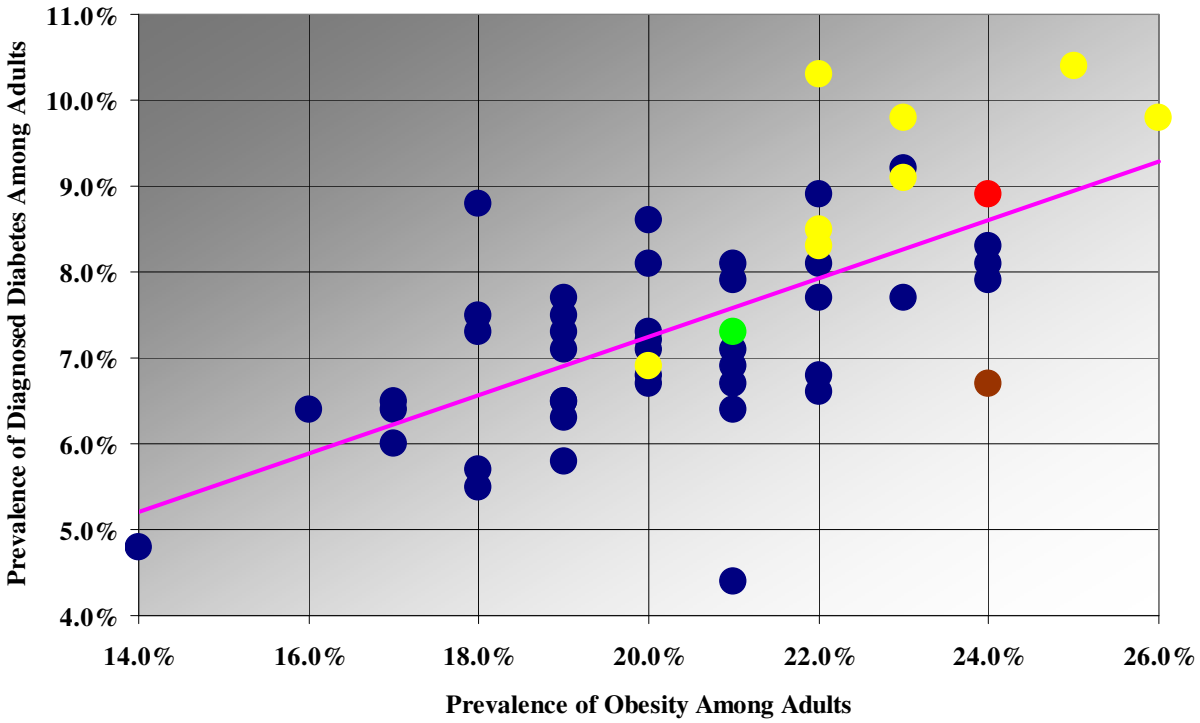



| | Percentage Beginning Prenatal Care In First Trimester | Preterm Births as a Percent of All Births |
|---|---|---|
| Kentucky | 74.5% | 14.4% |
| Alabama | 84.0% | 16.1% |
| Georgia | 83.9% | 12.8% |
| Mississippi | 84.4% | 17.9% |
| North Carolina | 84.0% | 13.5% |
| South Carolina | 68.0% | 15.5% |
| Tennessee | 69.8% | 14.5% |
| Virginia | 85.6% | 12.1% |
| West Virginia | 86.0% | 14.0% |
| United States | 83.9% | 12.5% |

*Source: Kaiser Family Foundation, www.statehealthfacts.org, 2004 data.*

Kentucky has a lower than average number of its residents seeking prenatal care in the first trimester than most states (and is only higher than two states in its comparator group), and has a higher percentage of preterm births when compared to the national average. Kentucky falls in the midrange of comparator states.

*Exhibit XXVII*
**Correlation Between Adult Obesity and Prevalence of Adult Diagnosed Diabetes**

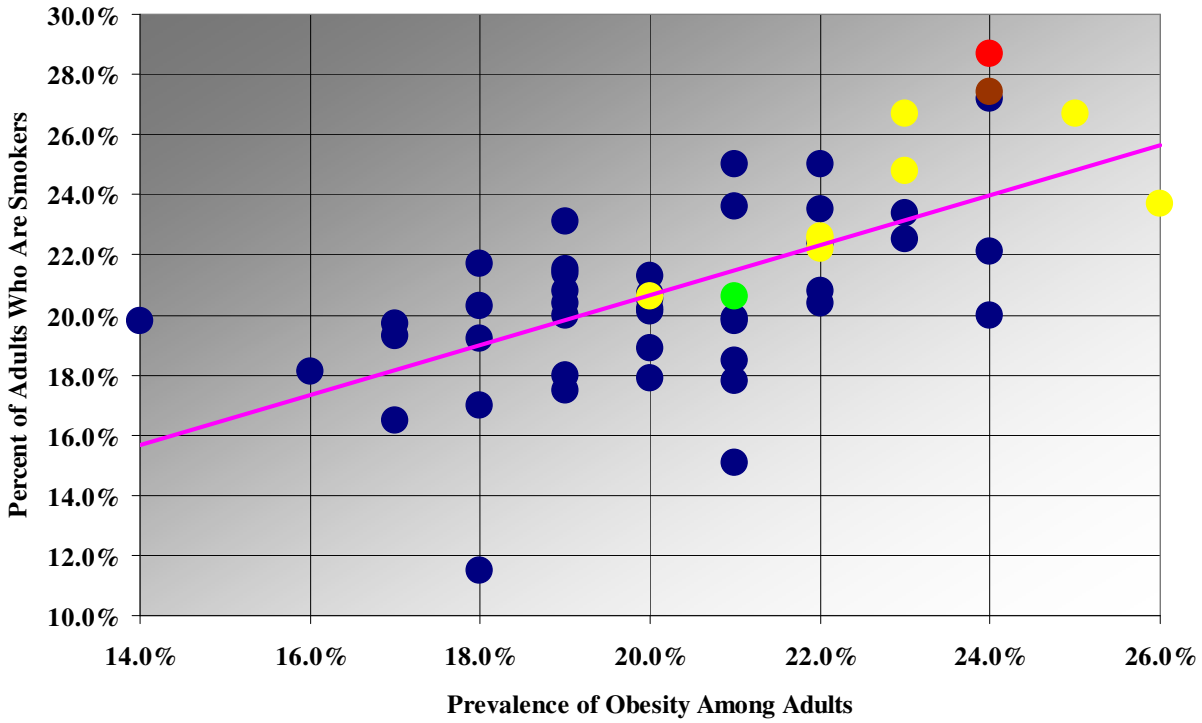



| | Prevalence of Obesity Among Adults | Prevalence of Diagnosed Diabetes Among Adults |
|---|---|---|
| Kentucky | 24.0% | 8.9% |
| Alabama | 23.0% | 9.8% |
| Georgia | 22.0% | 8.3% |
| Mississippi | 26.0% | 9.8% |
| North Carolina | 22.0% | 8.5% |
| South Carolina | 22.0% | 10.3% |
| Tennessee | 23.0% | 9.1% |
| Virginia | 20.0% | 6.9% |
| West Virginia | 25.0% | 10.4% |
| United States | 21.0% | 7.3% |

*Source: Kaiser Family Foundation, www.statehealthfacts.org, 2001 and 2002 data.*

Kentucky has one of the largest prevalences of obesity among adults in the country (24%). Only West Virginia (25%) and Mississippi (26%) have higher prevalences. As a health risk, obesity is correlated to a number of health conditions including diabetes, low back pain, and circulatory conditions. However, for states with a similar percentage of obese residents, Kentucky has a smaller prevalence of diagnosed diabetes among adults than that experienced by these other states. Nonetheless, Kentucky is in the 60$^{th}$ percentile for diabetes in the US (i.e., 60 percent of states have lower measures). Obesity is one of the high risk criteria identified by the HMRC that significantly raises current and future healthcare costs.

*Exhibit XXVIII*
**Correlation Between Adult Obesity and Percent of Adults Who Are Smokers**



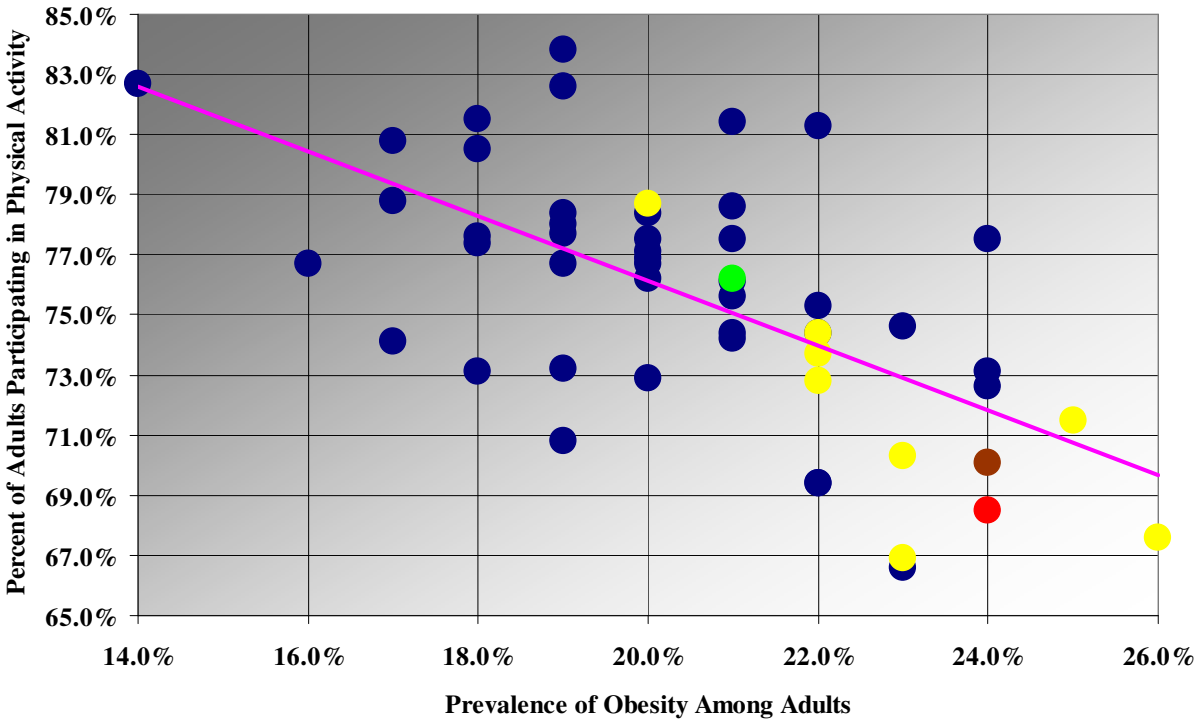

| | Prevalence of Obesity Among Adults | Percent of Adults Who Are Smokers |
|---|---|---|
| Kentucky | 24.0% | 28.7% |
| Alabama | 23.0% | 24.8% |
| Georgia | 22.0% | 22.2% |
| Mississippi | 26.0% | 23.7% |
| North Carolina | 22.0% | 22.6% |
| South Carolina | 22.0% | 22.5% |
| Tennessee | 23.0% | 26.7% |
| Virginia | 20.0% | 20.6% |
| West Virginia | 25.0% | 26.7% |
| United States | 21.0% | 20.6% |

*Source: Kaiser Family Foundation, www.statehealthfacts.org, 2001 and 2005 data.*

Kentucky has the highest percentage of adults who are smokers in the nation. As noted above, Kentucky also has one of the largest percentages of obesity among adults in the country (24%). While the KEHP program differentiates its employee contributions between smokers and non-smokers, the differential is not sufficient to cover the expected difference in claims for smokers versus non-smokers. Smoking is one of the high risk criteria identified by the HMRC.

*Exhibit XXIX*

**Correlation Between Adult Obesity and Adults Participating in Physical Activity**

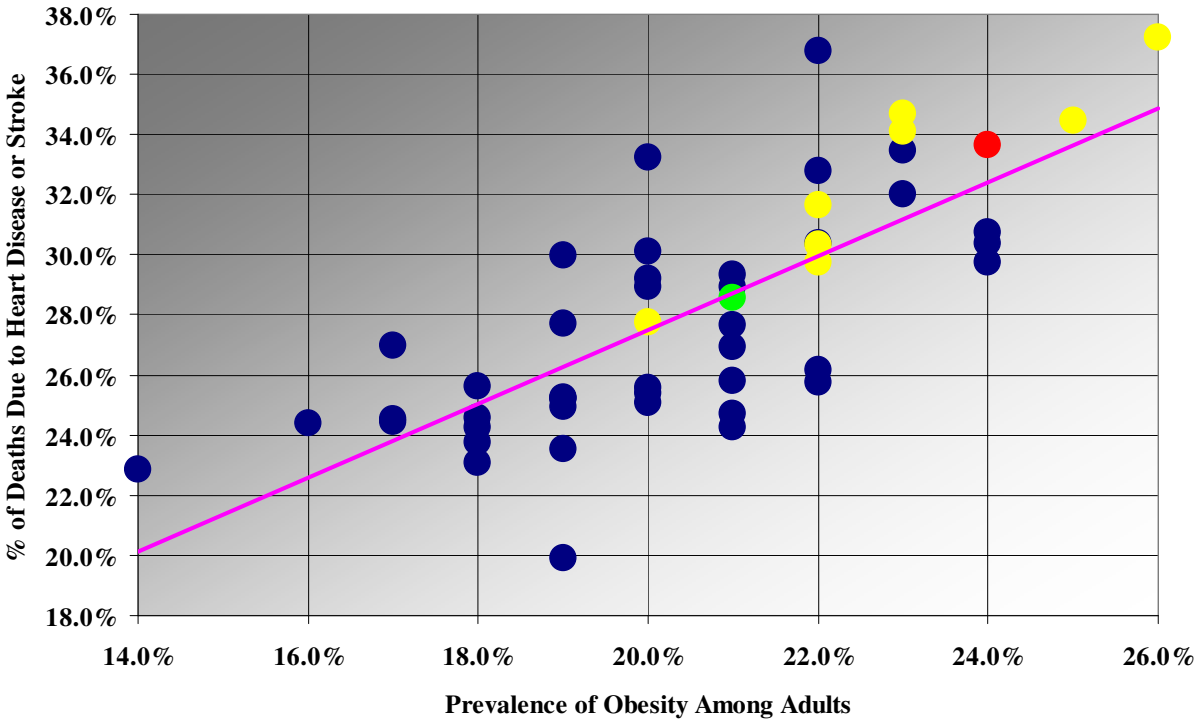



| | Prevalence of Obesity Among Adults | Percent of Adults Who Are Participating In Physical Activity |
|---|---|---|
| Kentucky | 24.0% | 68.5% |
| Alabama | 23.0% | 70.3% |
| Georgia | 22.0% | 72.8% |
| Mississippi | 26.0% | 67.6% |
| North Carolina | 22.0% | 74.4% |
| South Carolina | 22.0% | 73.7% |
| Tennessee | 23.0% | 66.9% |
| Virginia | 20.0% | 78.7% |
| West Virginia | 25.0% | 71.5% |
| United States | 21.0% | 76.2% |

*Source: Kaiser Family Foundation, www.statehealthfacts.org, 2001 and 2005 data.*

Kentucky has the fourth lowest percentage of adults who have participated regularly in physical activity. This characteristic correlates closely with the percentage of obesity among adults reported by Kentucky. Lack of regular physical activity is one of the high risk criteria identified by the HMRC.

*Exhibit XXX*
**Correlation Between Adult Obesity and Deaths Due to Heart Disease or Stroke**




| | Prevalence of Obesity Among Adults | Percent of Deaths Due to Heart Disease or Stroke |
|---|---|---|
| Kentucky | 24.0% | 33.6% |
| Alabama | 23.0% | 34.7% |
| Georgia | 22.0% | 31.6% |
| Mississippi | 26.0% | 37.2% |
| North Carolina | 22.0% | 29.8% |
| South Carolina | 22.0% | 30.4% |
| Tennessee | 23.0% | 34.1% |
| Virginia | 20.0% | 27.7% |
| West Virginia | 25.0% | 34.5% |
| United States | 21.0% | 28.6% |

*Source: Kaiser Family Foundation, www.statehealthfacts.org, 2001 and 2003 data.*

Kentucky has the sixth highest percentage of deaths attributable to heart disease or stroke (only Oklahoma, Alabama, Mississippi, Tennessee, and West Virginia have higher percentages). Again, this characteristic correlates closely with the percentage of obesity among adults reported by Kentucky. Obesity is one of the high risk criteria identified by the HMRC.

## Diagnostic Categories

The top eight Major Diagnostic Categories (MDCs) in exhibit XXXI represent over 69% of the total net medical and prescription drug payments made by the Commonwealth. This distribution of claims by MDC is reflective of the high average age of the covered population as well as some of the health risks reviewed earlier that may be prevalent in the covered population. The high relative cost of Musculoskeletal, Circulatory, and Digestive MDCs (Exhibit XXXI) suggest that potential care management and pharmacy programs related to these diagnoses should be taken full advantage of where they exist. For example, a targeted low back, heart disease, and ulcer disease management program and pharmaceutical step therapies, used to their best capacity could help manage these costs as well as the patients who have these diagnoses.

***Exhibit XXXI***
**Diagnosis Issues—2005 and 2006 Top 25 Major Diagnostic Categories (MDC)**

| Major Diagnostic Category | % Claims Distribution | |
|---|---|---|
| | 2005 | 2006 |
| Musculoskeletal | 14.57% | 15.43% |
| Circulatory | 15.18% | 14.47% |
| Digestive | 10.07% | 10.24% |
| Health Status | 6.37% | 6.98% |
| Skin, Breast | 5.90% | 5.94% |
| Nervous | 5.90% | 5.89% |
| Respiratory | 5.31% | 5.43% |
| Ear, Nose, Mouth & Throat | 4.84% | 4.86% |
| Kidney | 5.30% | 4.73% |
| Female Reproductive | 3.75% | 3.84% |
| Metabolic | 3.91% | 3.72% |
| Myeloproliferative Diseases | 3.44% | 3.16% |
| Liver, Pancreas | 2.76% | 2.86% |
| Pregnancy, Childbirth | 2.81% | 2.74% |
| Blood | 1.50% | 1.85% |
| Eye | 1.84% | 1.74% |
| Mental | 1.30% | 1.48% |
| Newborns | 1.75% | 1.39% |
| Infections | 1.29% | 1.12% |
| Injuries, Poisonings | 1.00% | 0.99% |
| Male Reproductive | 0.83% | 0.85% |
| Alcohol/Drug Use | 0.17% | 0.21% |
| Burns | 0.07% | 0.04% |
| ~Missing/Invalid Diagnosis | 0.13% | 0.02% |
| HIV Infections | 0.01% | 0.02% |
| **Total** | **100.00%** | **100.00%** |

*Source: Commonwealth's claims data aggregated by MedStat.*

## Detailed Pharmacy Experience

**Key Findings & Considerations**

- Pharmaceutical expenditures have been increasing steadily for the KEHP Program year over year, and 2006 was no exception. As in 2005, the Program's 2006 pharmacy cost increase outpaced the increase in cost for the other services covered. From 2005 to 2006, total allowed charges for pharmacy increased 14.8% while the Commonwealth's cost increased by 29.7% due to lack of increases in copayments and a decrease in the generic copayment.
- Increases in pharmacy usage for the Program coupled with increases in mail order utilization have more than offset other shifts in the pharmaceutical environment that may have helped limit cost growth, such as the increasing availability of new generics.
- The average number of prescriptions per member per year rose in 2006 to 19.5 from 17.9.
- The use of generic medications rose dramatically for the Program in 2006 to 54.5%, up from 49.2% in 2005 and 45.9% in 2004, most likely due to the number of blockbuster drugs which have lost patent protection and are now available as generics.
- The use of brand drugs continued to decline, dropping from 54.1% in 2004 to 50.8% in 2005 and further still to 45.5% in 2006. Use of single source brand drugs continues to drop - 39.8% in 2006 versus 44.2% in 2005. This is particularly desirable as both retail and mail order discounts achieved for single source brand drugs are lower than national benchmarks. The Program achieved a single source retail discount of 13.1% in 2005, and 14.4% in 2006. Mail order discounts for single source brand drugs decreased in 2006 to 17.2% from 18.7% in 2005.

Additional facts and figures in support of these findings, along with some additional analysis, are provided in the following section.

## Detailed Findings - Pharmacy

A summary of year over year trends for the Commonwealth's pharmacy claims experience in aggregate are illustrated in Exhibit XXXII.

***Exhibit XXXII***
**Key Pharmacy Statistics**

| | Annual Experience | | | | |
|---|---|---|---|---|---|
| | 2004 | 2005 | 2006 | 2005 vs. 2004 | 2006 vs. 2005 |
| Total Eligible Members | 227,917 | 229,867 | 236,038 | 0.9% | 2.7% |
| Total Allowed Charges | $226,025,398 | $237,950,244 | $273,147,664 | 5.3% | 14.8% |
| Total Plan Claims Cost | $168,061,796 | $182,071,346 | $236,119,319 | 8.3% | 29.7% |
| Total Scripts: | 4,160,895 | 4,108,930 | 4,599,740 | (1.2%) | 11.9% |
| Mail Order Scripts | 45,822 | 69,359 | 91,866 | 51.4% | 32.5% |
| Retail Scripts | 4,115,073 | 4,039,571 | 4,507,874 | (1.8%) | 11.6% |
| Brand Scripts | 2,253,058 | 2,086,751 | 2,091,591 | (7.4%) | 0.2% |
| Generic Scripts | 1,907,837 | 2,022,179 | 2,508,149 | 6.0% | 24.0% |
| Days Supply | 112,948,808 | 112,438,024 | 130,059,056 | (0.5%) | 15.7% |
| Days Supply per Claim | 27.1 | 27.4 | 28.3 | 0.8% | 3.3% |
| Generic Dispensing Rate | 45.9% | 49.2% | 54.5% | 3.4% | 5.3% |
| Generic Substitution Rate | 84.7% | 88.2% | 89.2% | 3.5% | 1.0% |
| Mail Order Utilization | 1.1% | 1.7% | 2.0% | 0.6% | 0.3% |
| Retail Copayment per Claim | $15.39 | $14.89 | $9.42 | (3.3%) | (36.8%) |
| Retail Member Cost Share | 28.0% | 25.9% | 15.9% | (7.5%) | (38.6%) |
| Mail Copayment per Claim | $32.46 | $29.31 | $24.33 | (9.7%) | (17.0%) |
| Mail Member Cost Share | 20.4% | 15.8% | 14.7% | (22.5%) | (7.0%) |
| Total Copayment per Claim | $15.58 | $15.14 | $9.72 | (2.9%) | (35.8%) |
| Total Member Cost Share | 27.8% | 25.4% | 15.9% | (8.7%) | (37.5%) |
| Plan Claims Cost PMPY | $737.38 | $792.07 | $1,000.34 | 7.4% | 26.3% |
| Plan Claims Cost PMPM | $61.45 | $66.01 | $83.36 | 7.4% | 26.3% |
| Plan Claims Cost per Claim | $40.39 | $44.31 | $51.33 | 9.7% | 15.8% |
| Scripts PMPY | 18.3 | 17.9 | 19.5 | (2.1%) | 9.0% |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat.*

Households incurring more than 75 retail scripts per year are assessed reduced prescription drug copays after the 75th script. The distribution of retails scripts per household per year is illustrated in Exhibit XXXIII. In 2006, over 13,000 households had more than 75 retail scripts in the year (8.9% of the households). Almost 3% of the households had no prescription drug scripts in 2006.

***Exhibit XXXIII***
**Distribution of Annual Number of Scripts Per Household In 2006**

| Number of Retail Scripts | Number of Families | % of Families |
|---|---|---|
| 0 | 3,991 | 2.7% |
| 1 | 5,030 | 3.4% |
| 2 | 5,337 | 3.6% |
| 3 | 4,515 | 3.1% |
| 4 | 4,137 | 2.8% |
| 5 | 3,676 | 2.5% |
| 6 | 3,522 | 2.4% |
| 7 | 3,273 | 2.2% |
| 8 | 3,180 | 2.2% |
| 9 | 3,132 | 2.1% |
| 10 | 3,051 | 2.1% |
| 11 | 3,154 | 2.1% |
| 12 | 3,191 | 2.2% |
| 13 | 3,274 | 2.2% |
| 14 | 3,042 | 2.1% |
| 15 | 2,951 | 2.0% |
| 16 | 2,776 | 1.9% |
| 17 | 2,637 | 1.8% |
| 18 | 2,495 | 1.7% |
| 19 | 2,419 | 1.6% |
| 20 | 2,408 | 1.6% |
| 21-25 | 11,087 | 7.6% |
| 26-30 | 9,534 | 6.5% |
| 31-35 | 7,936 | 5.4% |
| 36-40 | 6,967 | 4.7% |
| 41-45 | 6,014 | 4.1% |
| 46-50 | 5,049 | 3.4% |
| 51-55 | 4,227 | 2.9% |
| 56-60 | 3,611 | 2.5% |
| 61-65 | 3,093 | 2.1% |
| 66-70 | 2,613 | 1.8% |
| 71-75 | 2,274 | 1.6% |
| 76-80 | 1,890 | 1.3% |
| 81-85 | 1,589 | 1.1% |
| 86-90 | 1,273 | 0.9% |
| 91-95 | 1,116 | 0.8% |
| 96-100 | 1,009 | 0.7% |
| 101-125 | 3,180 | 2.2% |
| 126-150 | 1,571 | 1.1% |
| 151-175 | 739 | 0.5% |
| 176-200 | 364 | 0.2% |
| 201-225 | 179 | 0.1% |
| 226-250 | 94 | 0.1% |
| 251-275 | 47 | 0.03% |
| Over 275 | 55 | 0.04% |
| Total | 146,702 | 100.0% |

Reduced copays apply

| **Over 75** | **13,106** | **8.9%** |
|---|---|---|

*Source: Commonwealth's claims data aggregated by MedStat.*

Observations from the key statistics summary include:

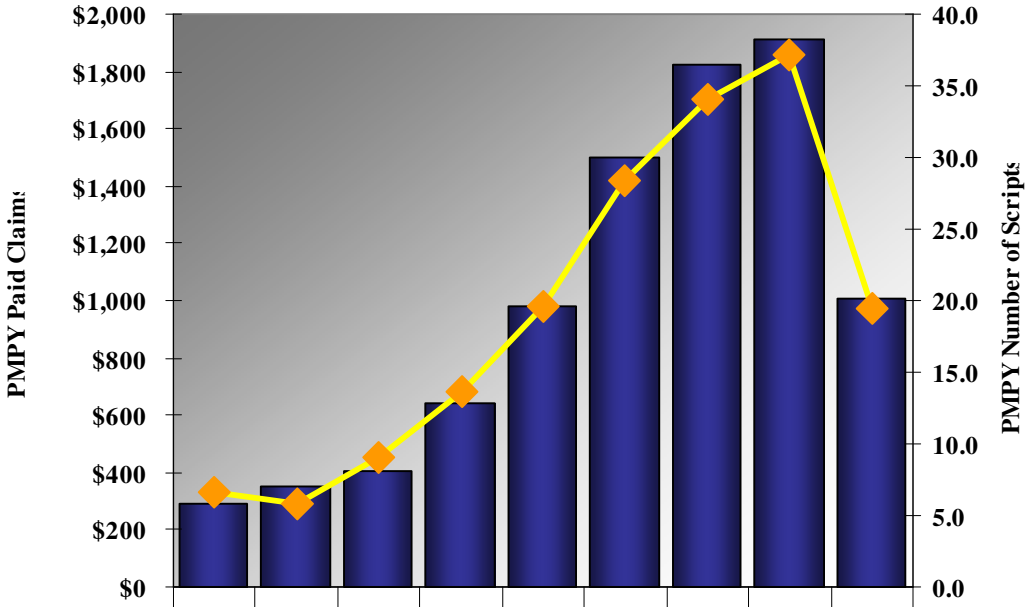
- The number of claims PMPY increased in 2006 to 19.5, compared to 17.9 in 2005.
- The use of generic medication is increasing to a 2006 Generic Fill Rate of 54.5%. With the increase in the number of new generics, this rate should be sustained in 2007 in the 60% to 63% range.
- Mail order usage is still low at 2%, but increasing each year. However, with the current cost share designs, use of mail order may not be a cost effective alternative for the Program.
- Use of brand-name drugs where generic is also available (i.e., "multi-source brand") decreased from a high of 6.6% in 2005 to 5.7% in 2006, due to the increased use of Generics. It is still high for the KEHP's demographics; a rate below 3% would be expected.

## Demographic Impact

In 2006 the member average age band of 30-39 has a pharmacy cost average of $641, up from $538 in 2005, and an average number of prescriptions of 13.6 versus 13.5 PMPY in 2005. The 40-49 age band, however, has an average pharmacy cost of $979, up from $839 and average number of prescriptions of 19.6 versus 19.1 PMPY in 2005.

As would be expected, older populations tend to use more chronic medications and thus have more prescriptions PMPY. The chart below illustrates the Commonwealth's utilization in the 50-74 year age bands to be well beyond industry norms, which typically range up to 26 claims PMPY. Note that the industry norms included here have not been adjusted to match the age, sex, and adult/child ratio characteristics of the Commonwealth's population.

***Exhibit XXXIV***
**2006 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Age**




| | < 10 | 10 - 19 | 20 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60 - 64 | >65 | Total |
|---|---|---|---|---|---|---|---|---|---|
| PMPY Paid Claims | $292 | $352 | $406 | $641 | $979 | $1,497 | $1,826 | $1,915 | $1,003 |
| PMPY Number of Scripts | 6.6 | 5.8 | 9.1 | 13.6 | 19.6 | 28.3 | 34.1 | 37.2 | 19.5 |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat.*

Membership and corresponding total expenditures are similarly consolidated in the older age bands. While the average member age is 37.8, the largest percentage of membership falls into an age band of 50-59 years, representing 24.8% of membership and 37% of total prescription drug plan cost ($1,497 PMPY), as reflected in Exhibit XXXV. Note that this exhibit includes only prescription drug claims experience, and excludes medical claims experience.

***Exhibit XXXV***
**2006 Distribution of Membership and Percent of Total Drug Plan Claims by Age**

| Age Group | Total Members | % of Total Members | % of Net Pay Rx |
|---|---|---|---|
| < 10 | 19,313 | 8.2% | 2.4% |
| 10 to 19 | 28,611 | 12.1% | 4.3% |
| 20 to 29 | 25,989 | 11.0% | 4.5% |
| 30 to 39 | 29,019 | 12.3% | 7.9% |
| 40 to 49 | 38,622 | 16.4% | 16.0% |
| 50 to 59 | 58,484 | 24.8% | 37.0% |
| 60 to 64 | 26,454 | 11.2% | 20.4% |
| >65 | 9,547 | 4.0% | 7.7% |
| Total | 236,038 | 100.0% | 100.0% |

*Source: Commonwealth's enrollment and prescription drug claims data aggregated by MedStat.*

## Drug Utilization and Disease States

A concentration of prescription drug plan costs can also be reviewed by drug-specific utilization and corresponding disease states being treated. For the KEHP Program in 2006, the top 30 drugs ranked by cost (Exhibit XXXVI) represented 39.3% of total pharmacy claims. By comparison, the top 30 drugs ranked by cost in 2005 represented 37.3% of total plan claims. Top 10 therapeutic categories and corresponding plan costs are provided in Exhibit XXXVII.

***Exhibit XXXVI***
**Top 30 Drugs**

| Drug Name | 2004 | | 2005 | | 2006 | | Net Pay Change | |
|---|---|---|---|---|---|---|---|---|
| | Rank | Net Pay PMPM | Rank | Net Pay PMPM | Rank | Net Pay PMPM | 2005 vs. 2004 | 2006 vs. 2005 |
| NEXIUM | 7 | $1.03 | 4 | $1.31 | 1 | $2.51 | 26.8% | 91.6% |
| ZOCOR | 4 | $1.35 | 7 | $1.19 | 2 | $2.20 | -12.0% | 85.3% |
| SINGULAIR | 6 | $1.09 | 5 | $1.29 | 3 | $1.86 | 17.7% | 44.2% |
| PREVACID | 2 | $1.48 | 9 | $1.07 | 4 | $1.72 | -27.9% | 61.4% |
| ENBREL | 22 | $0.52 | 2 | $1.50 | 5 | $1.68 | 186.1% | 11.7% |
| EFFEXOR-XR | 3 | $1.42 | 3 | $1.41 | 6 | $1.55 | -0.7% | 9.5% |
| CRESTOR | 37 | $0.35 | 35 | $0.38 | 7 | $1.29 | 9.9% | 236.0% |
| SIMVASTATIN | | | | | 8 | $1.26 | | |
| WELLBUTRIN XL | 16 | $0.64 | 12 | $0.88 | 9 | $1.25 | 36.5% | 43.3% |
| VYTORIN | | | 36 | $0.38 | 10 | $1.22 | | 217.8% |
| AVANDIA | 13 | $0.73 | 10 | $0.91 | 11 | $1.20 | 25.1% | 32.3% |
| TOPAMAX | 15 | $0.66 | 14 | $0.85 | 12 | $1.18 | 30.0% | 38.2% |
| LEXAPRO | 17 | $0.64 | 15 | $0.76 | 13 | $1.06 | 19.2% | 39.4% |
| PROTONIX | 10 | $0.84 | 6 | $1.22 | 14 | $1.03 | 45.4% | -15.9% |
| ACTOS | 11 | $0.78 | 13 | $0.87 | 15 | $0.93 | 11.0% | 7.2% |
| ZOLOFT | 5 | $1.22 | 8 | $1.12 | 16 | $0.87 | -8.5% | -22.3% |
| FEXOFENADINE HCL | | | 57 | $0.26 | 17 | $0.83 | | 219.8% |
| PLAVIX | 12 | $0.75 | 11 | $0.90 | 18 | $0.80 | 19.3% | -11.4% |
| LOTREL | 21 | $0.53 | 21 | $0.53 | 19 | $0.77 | 0.1% | 45.4% |
| ZYRTEC | 20 | $0.53 | 17 | $0.69 | 20 | $0.75 | 30.1% | 8.5% |
| TRICOR | 28 | $0.44 | 26 | $0.51 | 21 | $0.74 | 15.0% | 46.1% |
| LIPITOR | 1 | $2.90 | 1 | $3.13 | 22 | $0.74 | 7.9% | -76.4% |
| LEVAQUIN | 31 | $0.40 | 25 | $0.51 | 23 | $0.72 | 28.1% | 42.3% |
| ADVAIR DISKUS 250/50 | 26 | $0.47 | 19 | $0.58 | 24 | $0.72 | 24.3% | 22.9% |
| CELEBREX | 14 | $0.67 | 31 | $0.44 | 25 | $0.68 | -34.7% | 55.6% |
| CYMBALTA | | | 59 | $0.25 | 26 | $0.66 | | 161.3% |
| ZETIA | 38 | $0.32 | 30 | $0.44 | 27 | $0.66 | 36.5% | 50.4% |
| HUMIRA | 77 | $0.18 | 47 | $0.34 | 28 | $0.63 | 89.7% | 84.7% |
| IMITREX | 25 | $0.50 | 28 | $0.48 | 29 | $0.63 | -4.3% | 30.8% |
| COPAXONE | 57 | $0.26 | 24 | $0.52 | 30 | $0.62 | 101.4% | 20.0% |
| Total Top 30 (Each Year) | | $24.58 | | $26.56 | | $32.76 | 8.1% | 23.4% |
| All Other (Each Year) | | $36.87 | | $39.45 | | $50.60 | 7.0% | 28.3% |
| Total (Each Year) | | $61.45 | | $66.01 | | $83.36 | 7.4% | 26.3% |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat*

## *Exhibit XXXVII*
## 2006 Top 10 Therapeutic Class Summary

| Class Rank | Medstat Therapeutic Class (Intermediate) | Description | Net Paid | Scripts | Patients | Net Paid per Rx | Net Paid per Patient |
|---|---|---|---|---|---|---|---|
| 1 | Antihyperlipidemic Drugs, NEC | Treatment of High Cholestrol | $26,244,615 | 307,460 | 41,564 | $85.36 | $631 |
| 2 | Gastrointestinal Drug Misc,NEC | Ulcer Therapy/Hearburn | $20,611,177 | 168,678 | 29,829 | $122.19 | $691 |
| 3 | Psychother, Antidepressants | Antidepressants/Mental Health | $20,103,707 | 335,848 | 46,983 | $59.86 | $428 |
| 4 | Unclassified Agents, NEC | Miscellaneous Disease Treatment | $18,472,405 | 136,188 | 27,527 | $135.64 | $671 |
| 5 | Antidiabetic Agents, Misc | Treatment of Diabetes | $9,248,320 | 122,998 | 13,969 | $75.19 | $662 |
| 6 | Anticonvulsants, Misc | Treatment of Epilepsy | $8,228,749 | 61,669 | 10,213 | $133.43 | $806 |
| 7 | Antihistamines & Comb, NEC | Treatment of of Allergies | $6,944,566 | 200,562 | 63,133 | $34.63 | $110 |
| 8 | Adrenals & Comb, NEC | Treatment of Asthma (steriods) | $5,896,604 | 93,978 | 41,191 | $62.74 | $143 |
| 9 | Cardiac, Calcium Channel | Treatment of High Blood Pressure | $5,266,077 | 117,719 | 15,644 | $44.73 | $337 |
| 10 | Cardiac Drugs, NEC | Treatment of Heart Disease | $5,152,498 | 102,366 | 13,818 | $50.33 | $373 |
| **Top 10 Total** | | | **$126,168,719** | **1,647,466** | | **$76.58** | |
| **Grand Total** | | | **$236,119,319** | **$4,599,740** | | **$51.33** | |
| **Top 10 Percent of Total** | | | **53.4%** | **35.8%** | | | |

*Source: Commonwealth's enrollment and data claims aggregated by MedStat. All claims represented, including those classified by MedStat as "OTC and/or missing."*

Breaking the average number of prescriptions per person into single source brand, multi-source brand and generics, trends are similar to those seen in the aggregate data analysis (Exhibit XXXVIII). Use of brand single source and brand multi source drugs is on the decline, and use of generics is increasing.

## *Exhibit XXXVIII*
## Prescription Drug Utilization Detail by Drug Classification

| | Average Scripts Per Person | | |
|---|---|---|---|
| | 2005 | 2006 | % Change |
| ***Retail*** | | | |
| Brand Single Source | 7.7 | 7.6 | -2.3% |
| Brand Multi Source | 1.2 | 1.1 | -6.0% |
| Total Brand | 8.9 | 8.6 | -2.8% |
| Generic | 8.7 | 10.5 | 20.4% |
| **Total All** | **17.6** | **19.1** | **8.7%** |
| ***Mail Order*** | | | |
| Brand Single Source | 0.2 | 0.2 | 20.5% |
| Brand Multi Source | 0.0 | 0.0 | -7.2% |
| Total Brand | 0.2 | 0.2 | 17.4% |
| Generic | 0.1 | 0.2 | 49.2% |
| **Total All** | **0.3** | **0.4** | **29.0%** |
| ***Retail and Mail Order*** | | | |
| Brand Single Source | 7.9 | 7.8 | -1.8% |
| Brand Multi Source | 1.2 | 1.1 | -6.0% |
| Total Brand | 9.1 | 8.9 | -2.4% |
| Generic | 8.8 | 10.6 | 20.8% |
| **Total All** | **17.9** | **19.5** | **9.0%** |

*Source: Commonwealth's enrollment and claims data aggregated by MedStat.*

Step Therapy, a design that requires use of a generic or lower cost brand drug before use of a higher cost drug, is being used increasingly to generate generic utilization in classes where brands dominate the market share. The KEHP program has instituted step therapy.

Contributing to the mix of drugs used by the members are environmental changes, such as the introduction of new specialty drugs (driving a higher plan cost) and new generics (lowering plan cost). Based on the Program's historical experience, maximizing utilization of generics represents a significant opportunity to manage overall plan cost.

While patent expiration does not equal generic availability, several highly utilized drugs are scheduled for patent expiration over the next several years (Exhibit XXXIX).

***Exhibit XXXIX***
**Drugs Losing Patent Protection**

| Year | Brand Name | Manufacturer | Use |
|---|---|---|---|
| 2006 | Zocor | Merck | Hyperlipidemia (High Cholesterol) |
| | Zoloft | Pfizer | Depression |
| | Pravachol | Bristol-Myers-Squibb | Hyperlipidemia (High Cholesterol) |
| | Toprol-XL | AstraZeneca | Hypertension, CHF |
| | Zofran | GlaxoSmithKline | Nausea |
| | Allegra-D | Sanofi-Aventis | Allergies |
| | Ditropan XL | Otrho-McNeill | Overactive Bladder |
| | Activella | Novo Nordisk | Hormone replacement |
| 2007 | Norvasc | Pfizer | Hypertension |
| | Ambien | Sanofi-Aventis | Insomnia |
| | Zyrtec | Pfizer | Allergies |
| | Imitrex | GlaxoSmithKline | Migraine headache |
| | Lotrel | Novartis | High blood pressure |
| | Paxil CR | GlaxoSmithKline | Depression |
| | Coreg | GlaxoSmithKline | Hypertension |
| | Proscar | Merck | BPH |
| | Precose | Bayer | Type 2 diabetes |
| 2008 | Advair Diskus | GlaxoSmithKline | Asthma, COPD |
| | Risperdal | Janssen | Schizophrenia |
| | Fosamax | Merck | Osteoporosis |
| | Depakote | Abbott | Seizure disorder, bipolar disorder |
| | Mobic | Boehringer Ingelheim | Arthritis |
| | Serevent | GlaxoSmithKline | Asthma, COPD |
| | Effexor | Wyeth-Ayerst | Depression, anxiety |
| | Tegretol-XR | Novartis | Seizures |
| | Requip | GlaxoSmithKline | Parkinson's disease |
| | Tarka | Abbott | High blood pressure |
| | Mavik | Abbott | High blood pressure |
| | Kytril | Roche | Chemotherapy-induced nausea / vomiting |
| 2009 | Prevacid | Novartis | Ulcers, GERD |
| | Topamax | Ortho-McNeil | Seizures, migraine |
| | Lamictal tablets | GlaxoSmithKline | Siezures, bipolar disorder |
| | AcipHex tablets | Eisai | Ulcers, GERD |
| | Imitrex tablets | GlaxoSmithKline | Migraine headache |
| | Altace | King | High blood pressure |
| | Trileptal | Novartis | Seizures |
| | Clarinex | Schering | Allergies |
| | Casodex | AstraZeneca | Prostate cancer |
| | Prandin | Novo Nordisk | Type 2 diabetes |
| | Sonata | King | Insomnia |
| | Zerit | Bristol-Myers-Squibb | HIV/AIDS |
| | Acular | Allergan | Allergic conjunctivitis |
| | Aceon | Solvay | High blood pressure |
| | Glyset | Pfizer | Type 2 diabetes |

*Source: 2006 Medco Drug Trend Report*

## CREATING A SUSTAINABLE HEALTH PLAN: CONSIDERING HEALTH IMPROVEMENT, QUALITY IMPROVEMENT, COST & QUALITY TRANSPARENCY AS FOUNDATIONS

Concerns about ever increasing healthcare costs and questions regarding the quality of and access to care have become a well known refrain in the US's public arena. Anecdotal stories and news headlines focus on issues related to how to maintain and improve our healthcare system which is made up of stakeholders such as doctors, hospitals, insurers, and employers that operate in discrete silos, each with their own agenda. Discussion of drastic system wide changes has resurfaced time after time. The most significant of these include changing healthcare financing from today's model to government subsidized universal healthcare system; changing funding responsibility to the individual, for example through health reimbursement accounts (HRAs); or federal or state mandates for health insurance coverage for all. Yet, the change in ideology that would be required for such systemic modifications in the US healthcare system is charged by politics, history, and competing interests of stakeholders. Therefore, many US employers, plan sponsors and other payers today are focused on creating sustainable healthcare programs by improving the population's health and the quality of care provided.

The government, other payers, hospitals, and physicians are:

- Implementing initiatives to improve individuals' health through prevention, incentives for healthy behaviors and health improvement / wellness programs. A healthier population uses fewer services and less expensive services.
- Working to improve the quality of care provided by implementing monitoring programs and by increased consumer awareness. Reducing errors, unnecessary procedures, and redundant diagnostic procedures results in less cost and a healthier population.
- Making healthcare cost and quality information publicly available, or "transparent," giving individuals the critical information necessary to make value based decisions and better choices about their own care.

These three fundamentals, health improvement, quality, and transparency, are critical to a more efficient, safe, and sustainable healthcare program.

### Why Is This A Key Area of Focus?

The US spends more on health care as a portion of Gross Domestic Product (GDP) and per capita than any other country. In 2005, total health spending in the US accounted for 15.3% of GDP, compared to an average of 9% across member countries of the Organization for Economic Co-Operation and Development (OECD) based on the OECD statistics. The same report indicated that in 2005, US healthcare spending per capita was $6401 compared to an average of $2759 among OECD members. Yet, based on many key indicators, we have a less healthy population and poorer quality healthcare than many other developed countries. For example, according the World Health Organization (WHO), the US has the 6th highest percentage of obese adults, at 32.2%, of any country in the world and the highest among the OECD membership. The OECD reports that the US has a life expectancy that is one year below their

member countries' average, and higher infant mortality rate, at 6.8 deaths per 1,000 live births, than the OECD average which is 5.4.

Further, the cost burden of healthcare continues to be a number one issue for payers nationwide. And, for consumers, tools and information are not readily available to help them make the right choices. Consumers in America tend to be prudent buyers when buying other goods and services, but with healthcare people cannot judge the value of the service in order to make the best decision. They do not know what healthcare services actually cost or whether they are getting a high quality service.

By focusing on the areas outlined above, stakeholders in the US healthcare system hope that in the future, healthcare trend will abate, coming more into line with other services in the market. Patients will be able to choose their healthcare based on the value, balancing cost and quality in a way that best suits their needs. Hospitals, physicians and other service providers in the system will agree upon and accept standards of treatment that are based on evidence of solid and consistent outcomes that will improve the quality of care. And, given the right tools, individuals will have the motivation to pursue and sustain healthy lifestyles. All of these critical improvements ultimately result in a healthier population that utilizes preventive and routine services within parameters that are best for them, avoiding the high tech, high touch, and high cost services that are needed for those who are less healthy.

## Health Improvement - A Focus on Prevention and Chronic Disease

Chronic diseases such as diabetes, cardiovascular disease (heart failure and stroke), chronic respiratory disease (including chronic bronchitis and emphysema), and cancer, are high cost diseases that caused approximately 60% of deaths worldwide in 2005, according to WHO. Chronic disease is the leading cause of death and disability globally and increasingly affects poor- and middle-income countries as well as the most affluent. Individuals with these diseases can manage their diseases over the long term and can have productive lives post-diagnosis. To do this they must be compliant with treatment plans, including medication and medical intervention. Without careful management of these diseases the individuals will sustain significant additional treatment needs, including trips to the ER, hospitalizations, or complications that will significantly increase their healthcare cost and decrease their quality of life.

The good news is that these diseases are largely preventable. By reducing an individual's behavioral health risks such as smoking, poor nutrition, and lack of exercise, some chronic diseases may be avoided. The focus of the medical community historically has been towards treating disease rather than preventing it. Health improvement, or wellness, initiatives are becoming more prevalent as there is increasing evidence that prevention activities can not only reduce the diseases and the costs associated with them, but can also result in improved productivity in a population. The longer term affect of this improvement will be a critical support to a sustainable healthcare plan.

**Some Background Research - Working Towards Wellness**

PricewaterhouseCoopers' Health Research Institute, in conjunction with the World Economic Forum conducted research regarding the impact of chronic disease on global populations and identified best practices for developing, launching, and maintaining health improvement programs to prevent the spread of chronic disease. The resulting report, *Working Toward Wellness,* showed that chronic diseases continue to have a significant global impact.

Some of the key findings from *Working Towards Wellness*, indicate that there are significant implications to chronic diseases in the workforce, beyond just medical costs and mortality.

- Chronic disease threatens the economic prosperity of US employers, global businesses and their workers. Though chronic diseases are perceived to be a problem of the elderly, chronic diseases are affecting people in the active workforce as well. Nearly half of the people who die from chronic diseases are younger than 70 years old. Deaths from chronic diseases are increasing significantly while deaths from infectious diseases, maternal and perinatal conditions and nutritional deficiencies are decreasing and this trend is expected to continue for the foreseeable future.

- Little attention has been paid to preventing chronic disease. Only 3% of all health spending in the Organization for Economic Cooperation and Development (OECD) countries was directed at prevention and public health in 2004. The World Health Organization (WHO) estimates that 36 million of a projected 388 million deaths from chronic disease worldwide could be averted in the next ten years through prevention and public health activities. Therefore, private organizations, plan sponsors, and others are stepping up to fill the gap in preventive care funding. The risk factors that lead to chronic disease are preventable, yet the situation is getting worse. The world now has more overweight people than hungry ones.

- Unhealthy employees work less and cost more. Chronic diseases generate expensive medical bills, but lost productivity exacts a higher toll on businesses. Across the globe, work is increasingly sedentary and stressful, two factors that aggravate chronic disease. With the majority of the population actively employed and spending an increasing amount of time on the job, the workplace is a logical place for prevention and health improvement programs, especially in the face of decreasing public funding.

## What Are The Health Risk Factors?

Preventable risk factors such as smoking, low physical activity, poor diet, stress, and excessive alcohol use lead to chronic disease - lifestyle interventions that include education, support, and incentives are necessary to improve health behaviors and therefore reduce chronic disease.

***Exhibit XL***
**Largely Preventable Risk Factors Leading to Chronic Disease**

| | Modifiable Risk Factors | | | | |
|---|---|---|---|---|---|
| Chronic Disease | Smoking | Physical Activity | Diet | Stress | Alcohol |
| Chronic Heart Disease, Stroke | ◆ | ◆ | ◆ | ◆ | ◆ |
| Cancer | ◆ | | ◆ | | |
| Diabetes | | ◆ | ◆ | | |
| Respiratory Disease | ◆ | | | | |

*Source: PricewaterhouseCoopers Health Research Institute Analysis*

## Health Risk in Employee Populations

In general, over 80% of healthcare costs for employers are attributable to the 25% of members in the moderate to complex health risk categories (consistent with the Commonwealth's results as presented in Exhibits XIX and XX). Those with the highest number of risk factors cost significantly more, therefore a two pronged approach is a focus of many plan sponsors - keep the well members well, and help the members with higher risks to reduce them, thus avoiding future cost.

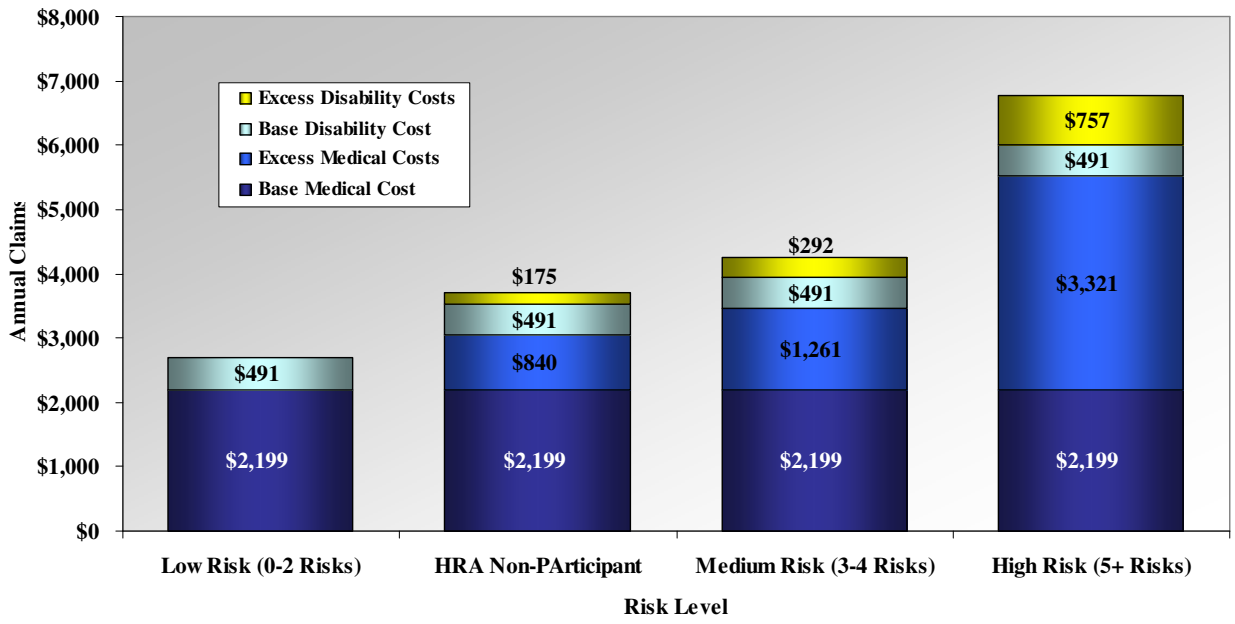
***Exhibit XLI***
**Cost of Employees to Health Plans**

| Chronic Disease | Well Members | Low Risk | Moderate Risk | High Risk | Complex and Intensive Care |
|---|---|---|---|---|---|
| Percent of Members | 50% | 25% | 20% | 4% | 1% |
| Percent of Healthcare Costs | 10% | 10% | 25% | 30% | 25% |

*Source: "Seven Ways to Demonstrate ROI: A Sherpa Model", by Michael Samuelson, Achieving Return on Investment for Wellness Conference, San Diego, October 23-25, 2006.*

In addition, there is a significant additional disability cost attributable to those employees who are moderate and high risk as self-reported on company sponsored health risk assessments (HRAs).

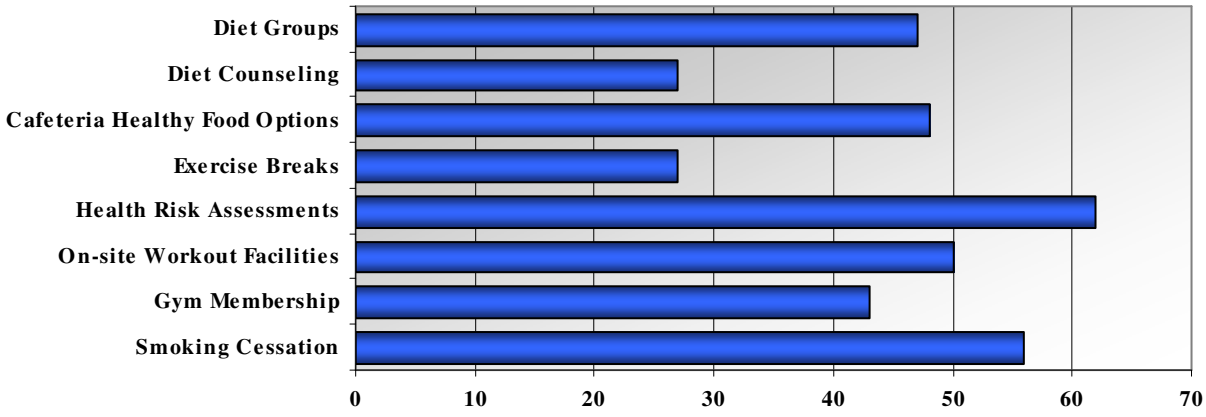
*Exhibit XLII*
**Excess Medical and Disability Costs**




*Source: D. Edington, AJHP 2001; 15(5):341-349*

Risk factor reduction is a broad-based approach used by plan sponsors to focus on unhealthy lifestyle choices. Often termed "wellness" or "health promotion," risk factor reduction refers to primary prevention, education, or other programs that are designed to assist an individual to maintain or improve their current level of health and well-being. Some of these programs have been included in benefits offered by employers for many years, however, the focus on increasing participation and measuring outcomes has been a newer occurrence, due to increased evidence that they can immediately impact both health of the employee and cost to the employer.

*Exhibit XLIII*
**Type of Wellness Programs Offered by 365 U.S. Companies**




*Source: ERISA Industry Committee (ERIC) 2005*

## Obesity

The best example of a health risk that, if modified, can reduce the chance of an individual developing a chronic disease is obesity. Obesity is projected to lead to 400,000 deaths annually. Those who are obese have 30% to 50% more chronic medical problems than those who smoke or drink heavily[1]. Body Mass Index (BMI), a calculation based on body weight and height, is an indicator of future healthcare spend - people with a BMI greater than 30 have 67% higher prevalence of chronic conditions, spend approximately 36% more than the general baseline population on health services, and spend 77% more on medications[2].

***Exhibit XLIV***
**Prevalence of Treated Disease by Body Mass Category**

| | Normal | Obese |
|---|---|---|
| Back Problems | 6.9% | 9.9% |
| Hypertension | 4.9% | 23.4% |
| Diabetes | 1.3% | 9.2% |
| Heart Disease | 3.7% | 7.5% |

*Source: Effects on Private Health Insurance Spending, Health Affairs, June 2005*

[1] *Healthy Bottom Line; State, Government, Businesses and Employers, Bearing Point, Inc.*

[2] *Rand Health*

## Improving the Quality of Care

### US Healthcare Quality - Mixed Results

Though the US leads the world in its spending on healthcare and in many areas of research related to it, there are discrepancies in areas of quality. The differences between where quality is at its best and worst in the US is in line with the historical focus on treating the most seriously ill rather than working towards wellness and prevention.

*High Quality*

- The US is the global leader in Nobel prizes for medicine, with 12 awarded to US scientists and three to foreigners in the US, vs. seven awarded abroad
- Four of the top six medical innovations were developed in the US: MRI/CT, statins, CABG, ACE inhibitors
- NIH's research budget is $28 billion vs. $3.7 billion for the whole EU

*Low Quality*

- The US ranks lowest of developed nations in life expectancy and infant mortality
- Only 55% of people in the US get recommended care
- 44-98,000 people in the US die annually from preventable medical errors
- The average hospital patient in the US experiences at least 1 medical error daily

### Measuring Quality - A Conundrum

Measuring quality of healthcare is a complicated undertaking. There is much discussion and disagreement among stakeholders on the appropriate metrics to use when measuring the quality of healthcare. What is important to some stakeholders is not as important to others. For example, patients and physicians view quality differently and what a patient considers important can vary widely from what a physician considers important. In this example the patients value getting clear information from physicians. Physicians are more concerned with logistical information.

*Exhibit XLV*
**Patient vs. Doctor Ratings of Important Factors**

| How Important Is It That… | Patient Rankings | Doctor Rankings |
|---|---|---|
| MD is skillful | 1 | 6 |
| MD is thorough | 2 | 11 |
| MD is truthful | 3 | 4 |
| MD takes patient seriously | 4 | 8 |
| MD builds trust | 5 | 2 |
| MD gives facts about risks/benefits | 6 | 58 |
| MD answers questions | 9 | 40 |
| MD explains medications | 12 | 82 |
| MD's diagnosis makes sense | 20 | 62 |
| Chart is there | 40 | 4 |
| MD doesn't embarrass patient | 60 | 13 |
| Staff are polite | 72 | 17 |
| Information is given privately | 80 | 10 |

*Source: Presentation by Tom Delbanco, MD, Koplow-Tullis Professor of General Medicine and Primary Care, Harvard Medical School, 2005*

Many government, private, provider based and other organizations have undertaken efforts to improve healthcare quality and measure results. An emerging structure for these efforts is based on the work of the Institute of Medicine (IOM). In 1996, the IOM began an effort to assess and improve the quality of care in the US. Their landmark report, *To Err is Human: Building a Safer Health System*, published in 1999, illustrated the shocking number of medical errors that occur in the US every year and the number of deaths that could be attributed to these errors. The IOM used these results to develop a vision of what a safe and high quality healthcare system should look like.

In 2001, the IOM published *Crossing the Quality Chasm: A New Health System for the 21st Century*. In this report, the IOM provided a "Call to Action" that operationalized the vision that was outlined in the 1999 report. They indicated that all healthcare organizations, professional groups, and public and private purchasers should pursue six major aims. Specifically, that healthcare should be:

- **Safe** - avoiding injuries to patients from the care that is intended to help them
- **Effective** - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit
- **Patient-centered** - providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions
- **Timely** - reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficient** - avoiding waste, including waste of equipment, supplies, ideas and energy.
- **Equitable** - Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status

These reports and subsequent studies from IOM and other research groups have driven awareness among stakeholders and initiated the focus on healthcare quality.

Better quality in healthcare will drive lower cost in addition to improving outcomes for individuals. Improving the level of patient safety in hospitals and the compliance with accepted standards of care would result in lower re-admission rates, fewer complications, and faster recovery time. In addition, an increase in prevention activities based on quality standards will result in the avoidance of the need for care.

"If all hospitals performed at the level of Distinguished Hospitals for Patient Safety ™, approximately 206,286 patient safety incidents and 34,393 Medicare deaths could have been avoided while saving the U.S. approximately $1.74 billion from 2003-2005" - HealthGrades, Fourth Annual Patient Safety in American Hospitals Study.

**Quality Indicators Available through the Kentucky Healthcare Information Center**

The Commonwealth of Kentucky's Healthcare Information Center provides reliable information for consumers to help them make the best, most informed decisions they can regarding their healthcare. The quality indicators that are available on the Kentucky Healthcare Information Center website include:

- Agency for Healthcare Research and Quality (AHRQ) and Department of Health and Human Services (DHHS) Quality Indicator Reports:
  - Prevention Quality Indicators (PQI) - indicates areas where good outpatient care can potentially prevent the need for hospitalization, complications, or more severe disease, for example:
    - Low birth rate
    - Diabetes short-term complication admission rate
    - Diabetes long-term complication admission rate
    - Chronic obstructive pulmonary disease admission rate
    - Congestive heart failure admission rate
  - Inpatient Quality Indicators:
    - Inpatient mortality for medical conditions, for example:
      - Acute Myocardial infarction (heart attack) mortality rate
      - Congestive heart failure (CHF) mortality rate
      - Acute stroke mortality rate
    - Inpatient mortality for surgical procedures, for example:
      - Coronary artery bypass graft (CABG - heart surgery) mortality rate
      - Percutaneous transluminal coronary angioplasty (PTCA) mortality rate
      - Craniotomy (brain surgery) mortality rate
      - Hip replacement mortality rate
    - Utilization of procedures for which there are questions of overuse, under use, or misuse, for example:
      - Cesarean delivery rate
      - Incidental appendectomy in the elderly rate
      - Bilateral cardiac catheterization rate
    - Volume of procedures for which there is evidence that a higher volume may be associated with better outcomes, for example:
      - Carotid endarterectomy mortality rate

## Healthcare Cost and Quality Information

Making critical healthcare cost and quality information transparent, or publicly available, could make a significant impact in the cost and outcomes of care for a plan. Providing members with tools to make value based decisions regarding their care and the care of their family members is critical to creating sustainability.

As discussed above, quality measures are varied and different stakeholders value different information, but as standards of care are accepted and reported and outcomes are judged important, the availability of quality measurement information will improve, allowing individuals to determine, along with their providers, what is most applicable to their circumstance. Since most people are aware only of their premium contribution rates for their health coverage and the copayments, and increasingly, coinsurance amounts that they pay for care, it is often a mystery what healthcare really costs or what makes it high quality.

### The Federal Value-Driven Health System Initiative - A Driving Force

The US Department of Health and Human Services has undertaken an initiative to drive transparency in healthcare. This initiative is based on the tenet of Secretary Michael Leavitt that "Every American should have access to a full range of information about quality and cost of their health-care options." The four cornerstones of the federal initiative are:

- Connecting the system
- Measuring and publishing quality
- Measuring and publishing price
- Creating positive incentives

The initiative is laying the foundation for pooling and analyzing information about procedures, hospitals and physician services in cooperation from the federal government, individual employers and health plans. The purpose is to develop a commitment to share information on price and quality of healthcare across stakeholders.

### Transparency Information available from the Kentucky Healthcare Information Center

The Kentucky Healthcare information center has hospital cost information online:

Consumers can review charge information based on top Diagnosis Related Groups (DRGs). Individual hospital and aggregate state data shows number of discharges, median charges, 10th and 90th percentile charges, median length of stay and median age by DRG. This, along with the quality data, can assist them in determining the best provider for their specific needs.

**Barriers to Quality Data and Transparency in the Healthcare System**

Quality and transparency of quality measures and cost are a major focus of the government, employers, health plans, providers, and other stakeholders in the US healthcare system. Yet, the development of these areas is complicated and slow. The multiple barriers to both quality information and transparency include:

- Multiple stakeholders with varying agendas and focus
- Lack of consensus on appropriate measures
- Concerns about competition and privacy
- Mistrust among stakeholders
- Need for interoperable information systems to support data collection

These barriers have been recognized, and attempts to overcome them are being made by stakeholders across the healthcare continuum. Progress is being made and is expected to continue as pressures continue to improve the cost and quality of healthcare in the US.

In summary, a focus on health improvement, quality improvement and transparency can be critical to maintaining a sustainable healthcare program.

## LEGISLATIVE MANDATES

The Department of Insurance provided the summary in Exhibit XLVI of twenty-nine mandated health insurance benefits that currently exist in Kentucky's statutes.

***Exhibit XLVI***

| Kentucky Mandated Health Insurance Benefits | |
|---|---|
| Newborn Coverage | KRS 304.17-042, KRS 304.18-032, KRS 304.32-153, and KRS 304.38-199. Coverage for newborn children from the moment of birth, including necessary care and treatment of medically diagnosed inherited metabolic diseases for newborns—KRS 304.17A-139(2). |
| Inherited Metabolic Disease | KRS 304.17A-139(4). Coverage for amino acid modified preparation and low protein modified food products for treatment of inherited metabolic diseases for conditions listed in KRS 205.560, if prescription drugs are covered. Benefits can be limited to $4,000 per year for low-protein modified foods and $25,000 per year for medical formulas. |
| Ambulatory Surgical Centers | KRS 304.17-317, KRS 304.18-035, & KRS 304.32-156. Coverage for treatment at ambulatory surgical centers. |
| Optometrists, osteopaths, physicians, podiatrists, and chiropractors | KRS 304-17-035, KRS 304.18-095, KRS 304.32-157 & KRS 304.38-195. KRS 304.17A-275 requires that coverage be provided for services provided by osteopaths. Osteopaths can also be PCP's. Services of these providers to be covered as described. |
| Chiropractors | KRS 304.17A-170 & 171. Access to chiropractors in network plans. |
| Dentists | KRS 304.17-315, KRS 304.18-097, KRS 304.32-157 & KRS 304.38-1937. Services of dentists to be covered as described. |
| Temporomandibular Joint Disorder | KRS 304.17-319, KRS 304.18-0365, KRS 304.32-1585 & KRS 304.38-1937. Coverage for specific services related to TMJ and associated disorders. Also see Administrative Regulation 806 KAR 17:090. |
| Screening Mammography | KRS 304.17-316, KRS 304.18-098, KRS 304.32-1591 & KRS 304.38-1935. Screening mammography at specific intervals. KRS 304.17-316(2)(b) requires mammography coverage at any age for a covered person diagnosed with breast cancer. |
| Breast Cancer | KRS 304.17-3165, KRS 304.17A-135, KRS 304.18-0985, KRS 304.32-1595 & KRS 304.38-1936. Coverage for the treatment of breast cancer, including ABMT. |
| Breast reconstruction coverage, endometriosis and endometritis | KRS 304.17-3163, KRS 304.18-0983, KRS 304.38-1934, KRS 304.32-1593 & KRS 304.17A-134. Coverage for the treatment of breast reconstruction. |

| Kentucky Mandated Health Insurance Benefits | |
|---|---|
| Psychologists and Clinical Social Workers | KRS 304.17-3185, KRS 304.18-0363, KRS 304.32-166 & KRS 304.38-1933. Services of these providers to be covered as described. |
| Registered nurse first assistant benefits | KRS 304.17A-146. Health benefit plans that cover surgical first assisting benefits or services must provide coverage for a registered nurse first assistant who performs the services within the scope of their license. |
| Conversion benefits | 2002 Ky. Acts, Chapter 351, Section 9. Maximum benefits of at least $500,000 for conversion policies—KRS 304.18-120(1). Minimum benefits—806 KAR 17:260. |
| Work Related Illness/Injuries | KRS 304.12-250. No contract can exclude coverage solely on the basis that the health condition is work related. |
| Disabled Children | KRS 304.17-310. Individual health insurance contracts must continue coverage for disabled children beyond the limiting age. Although this statute is applicable only to individual contracts, group carriers commonly use it. |
| Adopted Children | KRS 304.17-140. Coverage for legally adopted children or children under court-appointed guardianship. |
| Human Immunodeficiency Virus | KRS 304.12-013(5). No insurer or HMO may exclude or limit coverage for AIDS, etc. |
| Maternity Coverage | KRS 304.17A-145. Specified length of hospital stay following vaginal/cesarean deliveries. |
| Cochlear Implants | KRS 304.17A-131. Coverage for cochlear implants. |
| Autism | KRS 304.17A-143. Coverage for autism, including respite services. |
| Diabetes | KRS 304.17A-148. Coverage for diabetic services, supplies, and training. |
| Women's Health | KRS 304.17A-134, KRS 304.17-3163, KRS 304.18-0983, KRS 304.32-1593 & KRS 304.38-1934. Breast reconstruction, endometriosis, endometritis, and bone density testing. |
| Domestic Violence | KRS 304.17A-155. Claims may not be denied or considered pre-existing on the basis of domestic violence. |
| Hospice | KRS 304.17A-250(8). Coverage for hospice care equal to Medicare benefits. |
| Telehealth services | KRS 304.17A-138. (Effective when the plans are issued or renewed after July 15, 2001) |
| Mental health coverage | KRS 304.17A-661. Large group health benefit plans must cover mental illness the same as physical illness, if they provide mental illness benefits. |

| Kentucky Mandated Health Insurance Benefits | |
|---|---|
| Physician assistant benefits | KRS 304.17A-1473. Health Benefit Plans that cover surgical first assisting or intraoperative surgical care services must provide coverage for the services of a physician assistant. (Effective for Health Benefit Plans issued or renewed on or after July 15, 2001.) |
| Anesthesia and hospital or facility charges | 2002 Ky. Acts, Chapter 199. Requires coverage for payment of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems in all health benefit plans that provide coverage for general anesthesia and hospitalization services. |
| Hearing aids and related services | 2002 Ky. Acts, Chapter 106, Section 1(2). Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months. |

*Source: Kentucky Department of Insurance*

In addition to the mandated benefits outlined in Exhibit XLVI, there are other statutory requirements that affect the Public Employee Health Insurance Program. Exhibit XLVII provides a brief outline of the key provisions of the mandates enacted by the 2000 General Assembly that apply to health insurance programs. The provisions of those bills for which there is no check mark in the column titled "Impacts Commonwealth Plan" were covered by the Commonwealth's Public Employee Health Insurance Program prior to the enactment of the mandate.

***Exhibit XLVII***

| | Health Insurance Mandates Enacted By 2000 General Assembly | |
|---|---|---|
| | **Impacts KEHP Program** | **Key Provisions** |
| HB 9 | | Mammography coverage |
| HB 177 | | Coverage of Telehealth services |
| HB 202 | ✓ | ▪ Newborn coverage from moment of birth<br>▪ Treatment of inherited metabolic diseases including amino acid preparations and low-protein modified food products |
| HB 268 | ✓ | Mental Health Parity |
| HB 281 | | Coverage of services provided by registered nurse first assistants |
| HB 390 | ✓ | ▪ Utilization review rules<br>▪ Independent external review |
| HB 757 | ✓ | ▪ Hold harmless and continuity of care upon contract termination<br>▪ Drug formulary summary required at enrollment<br>▪ Network access requirements modified<br>▪ Prudent lay person standard for emergency services |
| SB 279 | ✓ | ▪ Prompt payment of medical claims |
| SB 335 | ✓ | ▪ Coverage of certified surgical assistants |

In addition to the health insurance mandates, Senate Bill 288, enacted by the 2000 General Assembly:

- Created the Kentucky Group Health Insurance Board.
- Required the Personnel Cabinet to develop healthcare data collection and analysis capabilities.
- Stipulated the conditions under which groups may leave the Public Employee Health Insurance Program.

- Revised the definition of "employee" with respect to the Commonwealth's healthcare and flexible spending account benefits.
- Required the Personnel Cabinet to report annually to the General Assembly on the financial stability of the Commonwealth's Public Employee Health Insurance Program.
- Required unused flexible spending account funds to be transferred to the state health insurance plan's appropriation account.
- Required carriers bidding to offer healthcare coverage to members of the Public Employee Health Insurance Program to rate all such members as single entity, except for those retirees whose former employers insure their active employees outside the Public Employee Health Insurance Program.
- Precluded certain individuals who are eligible for participation in the Public Employee Health Insurance Program as a retiree from receiving the state health insurance subsidy as an active employee as well.

Additional mandates enacted by the 2001, 2002, and 2003 General Assemblies affect the Commonwealth's Public Employee Health Insurance Program. These are summarized briefly in Exhibit XLVIII.

***Exhibit XLVIII***

| **Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program** | | |
|---|---|---|
| **Year Enacted** | **Bill** | **Key Provisions** |
| 2001 | HB 97 | The Office of Public Employee Health Insurance was established under the Personnel Cabinet. |
| 2001 | HB 138 | Coverage of physician assistants assisting in surgery. |
| 2001 | HB 145 | Personnel Cabinet and Cabinet for Families and Children to prepare recommendations regarding allowing foster parents to participate in the Public Employee Health Insurance Program. |
| 2002 | HB 39 | Coverage of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems. |
| 2002 | HB 163 | Expands Kentucky Group Health Insurance Board to include:<br>▪ The Director of the Administrative Office of the Courts<br>▪ KRS retiree<br>▪ KTRS retiree<br>▪ Active teacher<br>▪ Active state employee<br>▪ Active classified education support employee |
| 2002 | HB 369 | Mail order prescription drug coverage for Public Employee Health Insurance Program. |

| Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program | | |
|---|---|---|
| **Year Enacted** | **Bill** | **Key Provisions** |
| 2002 | HB 395 | Revised caps for inherited metabolic diseases to be $4,000 annually for low-protein modified foods and $25,000 annually for medical formulas. |
| 2002 | HB 801 | Entities that join the Kentucky Retirement System must join the Public Employee Health Insurance Program for their active employees. |
| 2002 | HB 821 | ▪ Personnel Cabinet to study whether to allow health insurance bidders to bid different rates in different geographic areas of the Commonwealth.<br>▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state subsidy for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does. |
| 2002 | HB 846 | ▪ Restricts individuals to one state subsidy for health insurance.<br>▪ Entities participating in the Public Employee Health Insurance Program must sign a contract with the Personnel Cabinet.<br>▪ Expands the Advisory Committee of State Health Insurance Subscribers to include 2 members from the Kentucky Association of Counties and 2 from the Kentucky League of Cities.<br>▪ Directs the LRC to study the cost to members of the state health insurance group as a result of entities covering their retirees under the Public Employee Health Insurance Program but not their active employees and recommend administrative procedures to collect this cost from these entities.<br>▪ Directs the LRC to study the Public Employee Health Insurance Program.<br>▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state subsidy for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does. |
| 2002 | SB 152 | Coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months. |
| 2002 | SCR 34 | Directs the Interim Joint Committee on Banking and Insurance to study the feasibility of self-funding at least one health insurance option for state employees. |
| 2003 | HB 95 | Removes the requirement that an employee's employment must be in the same county as his residence for the employee to be eligible to elect coverage in an adjacent county and receive the state subsidy for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does. |
| 2003 | HB 183 | Requires that the sponsor of a bill that contains a mandated health benefit request, have prepared, and attach a financial impact statement before final consideration by a standing committee. |
| 2003 | HB 370 | Required the Commonwealth's Public Employee Health Insurance Program to include a scenario that allows regional rating in its 2004 health insurance Request for Proposal, with regions defined as the partnership regions designated by the Department for Medicaid Services. |
| 2003 | HB 430 | For individuals hired on or after July 1, 2003, increased the service required of participants KRS from a minimum of 5 years to 10 years to be eligible to participate in the Commonwealth's retiree health insurance program. |

| Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program | | |
|---|---|---|
| **Year Enacted** | **Bill** | **Key Provisions** |
| 2006 | HB131 | Includes provision to pay optometrists the same amount as physicians or osteopaths when the services provided are rendered by an optometrist. |
| 2006 | HB131 | Adds language requiring the Kentucky Employees Health Plan to be in compliance with certain provisions of the Insurance Code, including appeals & grievance procedures, utilization review, claims payment, and emergency medical care. |
| 2006 | HB380 | Reduced the employer contribution for 2006 health insurance premiums by 12% for the period July – December, 2006. |
| 2006 | HB380 | Provided explicit statutory authority to establish a self-insured health plan for public employees. |
| 2006 | HB380 | Requires the plan to be established by administrative regulations. |
| 2006 | HB380 | Provides appeal rights for formulary changes, and ensures independent review of any proposed changes in formulary. |
| 2006 | HB380 | Establishes a Trust Fund for the plan, and defines the allowable expenses to be paid by the Trust Fund. |
| 2006 | HB380 | Requires a Health Reimbursement Account to be provided for those employees who waive coverage under the Plan, to be funded by the employer at an amount no less than $175 per month. |
| 2006 | HB380 | Requires an audit of the Trust Fund within 90 days of the end of each Fiscal Year. |
| 2006 | HB380 | Establishes quarterly reporting requirements for the Plan. |
| 2007 | SB22 | Create a new section of KRS Chapter 18A to require the Personnel Cabinet, Department for Employee Insurance, to offer TRICARE supplement insurance to eligible TRICARE insurance beneficiaries; require the Commonwealth to pay for individual TRICARE supplement insurance; permit an employee eligible for TRICARE to choose between the Commonwealth sponsored TRICARE supplemental insurance or other coverage offered through the public employee health insurance program; permit the secretary of the Personnel Cabinet to promulgate administrative regulations. Note this legislation is pre-empted by Federal law which prohibits employers from offering incentives to employees if they elect coverage under a Federally-sponsored program. |
| 2007 | SB175 | Amend KRS 304.17A-846 to direct health insurers to provide certain information to large group health benefit plans upon request of the plans; require the insurer to provide additional utilization data to help the employer measure costs in certain areas; provide under certain circumstances that nonpublic personal health information can be provided to large group health benefit plans in compliance with the Federal Health Insurance Portability and Accountability Act. |
| 2007 | HB378 | Amend KRS 216B.175 to require history and physical examinations to be performed no more than 30 days, rather than 7 days before admission to an acute care or psychiatric hospital. |

No additional benefit mandates were enacted by the 2004 General Assembly. In fact, House Bill 650 created a new statute in Subtitle 17A that imposed a 3-year moratorium on new mandated benefits beyond those statutorily required on July 13, 2004.

Many of the bills that were introduced during the 2007 Regular Session of the General Assembly would have had some impact on the Kentucky Employees Health Plan, but only a few were passed and enacted into Law. SB22 directly affected the plan, while SB175 and HB378 were directed at insurance plans in general.

## Conclusions

There are a significant number of legislative mandates that apply to the Commonwealth's Public Employee Health Insurance Program. The impact of many of these mandates on the program's costs is difficult to discern. And, although the discernible cost of some mandates may be low in a given year, significant variation can result from year to year. Finally, the ability to determine the cost of discrete provisions is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

## CONCLUSIONS

This section provides a consolidated summary of the conclusions presented in the previous sections of the report.

### Board Recommendations

The Board recommends the following:

- The Board recommends that the due date for the Annual Report to the Governor be extended from October 1 each year to December 1.
- Conducting a study to determine the cause(s) of, and tactics for improving, the population's increase in cost. Determine, for example, if there are specific clinical conditions, health behaviors, and/or utilization patterns that could be improved. The results of the study will be reviewed by the Board for feedback.
- Working with the disease management vendor to compare the top clinical conditions that are driving costs. Assess the impact of developing incentives and additional outreach programs to increase participation and return on investment for these conditions. Share the results of this assessment with the Board for review and feedback.
- Conducting a risk study for the population that models expected health risks that may be driving high costs and/or high utilization (e.g., obesity and low physical activity risks and resulting clinical conditions). Based on the risk study, investigate the impact of developing a strategy to implement an overall health improvement program that will promote a "culture of wellness" while providing incentives and rewards for participation. The study would be reviewed by the Board for feedback.
- Considering the impact of managing the generic prescription drug utilization through a member-pays-the-difference program and/or copay incentives to sustain a 60% or higher generic utilization. The Board will review the results and provide feedback.
- Reviewing brand name single source prescription drug discounts for both retail and mail to determine if they are at current market levels. The Board will review the results and provide feedback.
- Investigating the impact of discouraging the use of multi-source brand drugs through a member-pays-the-difference program or through an increased step therapy program to achieve a utilization of less than 3%.The Board will review the results and provide feedback.
- Assessing the current pharmacy mail order program to determine if copay designs ensure that mail order is cost effective (or the retail equivalent). If so, assess the impact of implementing a mail order (or the retail equivalent) incentive program, and if not, investigate the impact of adjusting copays. Further, evaluate whether or not the associated discounts are at best market levels. Consider the impact of implementing a mail order (or the retail equivalent) incentive program. For example, consider a program that after allowing an initial fill and two refills at retail outlets, requires that the next prescription be submitted to mail order (or apply mail order provisions as a retail equivalent). The Board will review the results and provide feedback.

- Investigating the impact of participating in a specialty pharmacy program which would provide 24/7 access to a pharmacist or nurse specialist to members, cover all necessary supplies for medication administration, and ensure appropriate utilization and adherence to prescribed regimen. The Board will review the findings and provide feedback.
- Considering the impact of refreshing plan designs for both medical and pharmacy benefits. This evaluation would be reviewed by the Board for feedback.

**General Observations on the KEHP Program**

The key findings and considerations from the Medical and Pharmacy Trends Analysis from 2005 to 2006 are as follows:

- The aggregate percentage increase (or "trend") in medical and pharmacy claims costs from 2004 to 2006 (inclusive of estimated IBNR) was 13.0% (total claims cost increase, both member and Commonwealth's). The increase per member per month was 12%.
- The aggregate percentage increase (or "trend") in medical and pharmacy claims costs from 2005 to 2006 (inclusive of estimated IBNR) was 20.3% (reflective of total claims cost increase, both member and Commonwealth's). The per member per month (PMPM) increase in this time period was 17.1%
- Non-Medicare eligible retirees' medical costs are approximately 1.7 times that of active employees while their pharmacy costs are approximately 2 times that of active employees. However, their rate of increase is lower than the active group.
- The distribution of the Commonwealth's medical and pharmacy claim costs by place of service has remained constant from 2005 to 2006.
- Utilization, by place of service (hospital, physician, etc.) remained relatively consistent from 2005 to 2006.

The key findings and considerations from the Enrollment and Demographic Analysis from 2005 to 2007 (estimate based on the first 6 months of 2007) are as follows:

- The total KEHP enrollment has grown by nearly 3%.
- On average, the 2006 population is younger than the 2005 population. This trend toward lower average age seems to be continuing in 2007 and is most likely driven by an increase in coverage for dependent children.
- The percentage of enrollees electing employee only coverage has decreased, with an increase in employee plus spouse and family coverage
- The ratio of the number of dependents enrolled to the number of employees enrolled has been consistent from 2004 to 2007.
- It has been noted in the past that some Medicare eligible plan participants (dependents of non-Medicare eligible retirees) do not have Medicare as their primary coverage *("primary" coverage refers to the plan that pays first, with secondary coverage only paying after the primary plan has paid)*, and that the PEHI Program coverage is being used as the primary

insurance in those instances. As the proportion of non-Medicare eligible retirees grows (and with them, presumably, Medicare eligible dependents) there will be an added cost impact due to the PEHI plans being used as the primary coverage.

- While non-Medicare eligible retirees account for 22.3% of plan membership in 2006, they account for:
  - 32% of medical costs
  - 37% of pharmacy costs
  - 33% of total healthcare costs
- Plan options and the employee contribution levels were revised for 2005. Employee contributions did not change between 2005 and 2006. Additionally, the select plan option was offered for the first time in 2006.
- 2006 employee contributions were frozen at the 2005 level. This may have influenced an increase in dependent enrollment. This trend seems to be continuing in 2007 .
- From 2005 to 2007, there is a slight decrease each year in enrollment in the Premier plan, with enrollment migrating to the Enhanced and Select plan.

The key findings and considerations from the Large Claims Analysis from 2005 and 2006 are as follows:

- While only 0.8% of members had claims totaling over $50,000 in 2006, these members consumed 20% of the Commonwealth's total paid claims expense for 2006.
- Approximately 19% of the population is generating approximately 73% of the medical and drug claims costs.
- The KEHP Program's large claim experience for 2006 corresponds closely to the expected number of claimants at the various actuarial benchmark claims levels.
- The KEHP Program's large claim experience is in line with benchmarks. However, the proportion of low users ($0 to $1,000 in claims) is substantially lower than expected. Note that the benchmark figures reflect submitted claims while the Commonwealth experience reflects paid claims. This difference would produce the most dramatic difference is actual versus benchmark measurement for the 2 smallest dollar claims bands, but would not impact the comparison above $5,000 in claims.
- The top three major diagnostic categories are consistent with 2005 and include musculoskeletal, circulatory and digestive.

The key findings and considerations regarding diagnosis & wellness issues from 2005 to 2006 are as follows:

- A high proportion of costs are incurred for treatment of participants with diagnoses that fall into a short list of major diagnostic categories. This list has remained constant from 2004 to 2006. This indicates that disease management efforts should continue to be targeted to the primary diagnosis categories of circulatory (e.g. heart and stroke), musculoskeletal (e.g. lower back), and respiratory (e.g. asthma and pulmonary disease).
- In 2006, ActiveHealth identified 40,199, or 16.8% of KEHP members with at least one chronic condition that could be managed through the ICM program. During the year, 6% of KEHP members received program and disease information either via mail or telephonically with a nurse. 3,595 are receiving scheduled phone calls from a nurse.
- KEHP members have met colon wellness screening targets. Members lag in other screening areas.
- The Commonwealth's overall population, of which the KEHP membership is a significant component, continues to exhibit serious population health issues, including preterm births, obesity, adult diabetes, smoking, lack of physical activity and deaths due to heart attack and stroke. These health risks can be improved through behavioral change.

The key findings and considerations regarding prescription drug issues from 2005 to 2006 are as follows:

- Pharmaceutical expenditures have been increasing steadily for the KEHP Program year over year, and 2006 was no exception. As in 2005, the Program's 2006 pharmacy cost increase outpaced the increase in cost for the other services covered. From 2005 to 2006, total allowed charges for pharmacy increased 14.8% while the Commonwealth's cost increased by 29.9% due to lack of increases in copayments and a decrease in the generic copayment.
- Increases in pharmacy usage for the Program coupled with increases in mail order utilization have more than offset other shifts in the pharmaceutical environment that may have helped limit cost growth, such as the increasing availability of new generics.
- The average number of prescriptions per member per year rose in 2006 to 19.5 from 17.9.
- The use of generic medications rose dramatically for the Program in 2006 to 54.5%, up from 49.2% in 2005 and 45.9% in 2004,, most likely due to the number of blockbuster drugs which have lost patent protection and are now available as generics.
- The Program also saw its use of brand drugs continuing its declining trend, dropping from 54.1% in 2004 to 50.8% in 2005 and further still to 45.5% in 2006. Use of single source brand drugs continues to drop - 39.8% in 2006 versus 44.2% in 2005. This is particularly desirable as both retail and mail order discounts achieved for single source brand drugs are lower than national benchmarks. The Program achieved a single source retail discount of only 13.1% in 2005, and 14.4% in 2006. Mail order discounts for single source brand drugs decreased in 2006 to 17.2% from 18.7% in 2005.

## GLOSSARY

**Allowed Charge:** The amount paid in total to a healthcare provider for services received by a health plan member. This amount includes both the health plan's payment and the member's cost sharing (deductible, co-payment, co-insurance, etc.). This is the total amount billed by a healthcare provider for a covered service, after the application of the health plan's negotiated discount, but prior to any member cost-sharing.

**Brand Name Drug:** A trademarked drug for which the manufacturer holds the patent or has purchased the rights to manufacture from the patent holder. Brand name drugs are generally more expensive than generics. A single-source brand name drug is a drug that is only produced by one manufacturer and for which a generic equivalent is not available. Multi-source brand name drugs are drugs produced by more than one manufacturer, as generic equivalents are available.

**Capitation:** A set amount of money paid to a provider of service based on membership demographics rather than payment based on services provided.

**COBRA Beneficiaries:** Individuals who no longer meet the eligibility requirements for healthcare coverage through a group health plan, but by federal statute, are eligible to continue their healthcare coverage for a period of time under the employer's healthcare program by paying 102% of the total premium rate.

**Co-Payment:** A stipulated dollar amount that a health plan member must pay out of pocket when healthcare services, supplies, or prescription drugs are received.

**Coinsurance:** A percentage of the cost of covered healthcare services, supplies, or prescription drugs that a health plan member must pay out of pocket.

**Coverage Tier (also referred to as Coverage Level):** The choices available to employees with respect to the individuals they wish to cover under an employer's health insurance program. Under the Commonwealth's Public Employee Health Insurance Program, the following tiers (or levels) apply:

- Single: coverage for only the employee or retiree
- Couple: coverage for the employee or retiree and his/her spouse
- Parent Plus: coverage for the employee or retiree and all eligible children
- Family: coverage for the employee or retiree, his/her spouse and all eligible children

**Dependent Subsidy:** When an employer specifically pays a portion, or all, of the dependent premium for an employee, this is an *explicit dependent* subsidy. When the differential between single and dependent healthcare premium rates is less than the differential between employee/retiree healthcare claims and dependents' healthcare claims, an *implicit dependent subsidy* exists.

**Employee:** References to "Employees" includes Active Employees, non-Medicare-eligible retirees, and COBRA participants. When meant to reflect only those employees still actively at work, the term "Active Employees" will be used.

**Exclusive Provider Organization (EPO):** These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Depending on the insurance carrier chosen, the participant may or may not have to designate a primary care physician to coordinate his/her care. Beginning January 1, 2000, EPO Option C was added to the Commonwealth's Public Employee Health Insurance Program.

**Formulary:** A preferred list of medications developed by a health plan or Pharmacy Benefit Manager (PBM) to guide physician prescribing and pharmacy dispensing. This list is periodically updated by the PBM to add or remove drugs.

**Flexible Spending Account (FSA):** A flexible spending account or reimbursement account is funded by employee salary reductions, employer contributions or both. Amounts placed in these accounts are used to provide reimbursement for eligible expenses incurred by the employee or eligible beneficiaries for specified benefits during a plan year.

**Fully Insured** (**also referred to as Insured or Fully Funded):** When a health plan assumes the financial risk associated with medical expenses for an employer group in exchange for the premiums paid by the group.

**Generic Drug:** A drug whose therapeutic ingredients are the same as a brand name drug, but which is sold under a name that is not trademarked. Generic drugs are usually less expensive than their brand name counterpart.

**Health Maintenance Organization (HMO):** These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Participants in these plans must select a primary care physician to coordinate their care. For the majority of the services covered by the HMO, participants pay a specified dollar amount (co-payment) at the time services are received.

**Medical Loss Ratio** (**also referred to as Loss Ratio):** The ratio between the incurred claims paid by a health plan and the premium taken in by the health insurer. Example: An insurance company receives $100,000 in premium for a month and pays out $89,000 in claims–the Medical Loss Ratio is 89% ($89,000/$100,000).

**Out-of-Pocket Limit:** A specified dollar amount present in some health plan provisions that limits the amount of out-of-pocket expenses a plan participant pays in a Plan Year for covered healthcare services. Once the participant reaches the out-of-pocket limit, the health plan pays 100% of his/her covered healthcare expenses for most or all services.

**Pharmacy Benefit Manager (PBM):** An organization that functions as a third party administrator for a health plan's pharmacy claims, contracts and management.

**PMPM (Per Member Per Month):** A measure of costs as expressed as total costs divided by total number of covered lives (employees, spouses, and dependent children).

**Point of Service (POS):** These plans mimic the benefits of the HMO options, provided an individual receives services from a healthcare provider that has contracted with the health plan and services are coordinated through the primary care physician designated by the individual. Unlike the HMO options, the POS options provide coverage for services received from a provider that is not in the health plan's network, at a higher cost sharing percentage to the insured.

**Preferred Provider Organization (PPO):** These plans require lesser cost sharing from participants, if covered services are received from a healthcare provider that participates in the health plan's network. Coverage is provided for services received from a provider that is not in the health plan's network, with participants paying a larger proportion of the cost of covered services. Unlike POS plans, PPOs do not require referrals from a participant's primary care physician. The PPOs offered under the Commonwealth's Public Employee Health Insurance Program provide the same benefits for services received in a network physician's office and for prescription drugs as do the HMO and POS options. However, for services received in a network hospital or surgical center, PPO participants pay a percentage of the cost of services received (co-insurance) after paying an annual deductible, rather than a specified dollar co-payment. The amount of co-insurance that a participant pays annually is capped by the PPO plan's out-of-pocket limit.

**Premium:** The monetary amount paid by an employee or the employer for health insurance benefits. It is routinely paid on a monthly basis. In an insured program, the amount paid to an insurance company in exchange for its payment of all healthcare costs covered under the terms of the health plan and for administrative services. For large groups, like the Public Employee Health Insurance Program, premiums are determined based on the healthcare services consumed by the plan's members in the past and the prices charged by healthcare providers. If the premiums charged by the insurer are less than the actual healthcare costs incurred by the plan's members and the insurer's operating costs, the insurer loses money. The premium includes both the employer's subsidy and the employees' contributions for health insurance.

**Premium Equivalent:** Analogous to "Premiums," Premium Equivalents reflect the expected actuarial costs for a plan option and coverage tier under a self-insured arrangement.

**Primary Care Physician:** For purposes of the applying the Commonwealth's qualifying network requirements, a primary care physician includes: family practice physicians, general practice physicians, pediatricians, and internists.

**Provider Network:** A list of contracted healthcare providers, unique to a health plan, from which an insured can obtain services that are covered under an HMO or are covered at a preferred benefit level under a POS or PPO.

**Self Insured (also referred to as Self Funded):** A health plan whose medical claims' financial risk is assumed by the employer and not by the health plan.

**Specialist Physician:** For purposes of the applying the Commonwealth's qualifying network requirements, a specialist physician includes all physicians other than: family practice physicians, general practice physicians, pediatricians, and internists.

**Stop Loss Coverage:** Stop loss coverage is insurance that covers a health plan's expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). This coverage is also referred to as **Excess Loss Coverage.**

**Third Party Administrator (TPA):** An organization that performs health insurance administrative functions (e.g. claims processing) for a plan or an employer. The TPA may also provide the healthcare provider network.

**Unescorted Retirees:** Individuals who participate in a state sponsored retirement program are eligible to participate in the Public Employee Health Insurance Program. These retirees include not only former employees of state agencies and school districts, but also former employees of cities, counties, and municipalities that participate in the County Employees Retirement System (CERS) and former employees of regional universities. Health insurance coverage for the pre-65 retirees of the Commonwealth's KTRS and KRS programs is provided through the same program that covers active state employees. However, active employees of the Commonwealth's regional universities do not participate in the Public Employee Health Insurance Program, neither do active employees of most of the cities, counties and municipalities that participate in the CERS program. Rather, these entities maintain separate health insurance programs for their active employees. In the analysis conducted by the Segal Company in October 2002 at the request of the Interim Joint Committee on State Government, the term "unescorted retirees" was assigned to this group of retirees.

**Waiver:** An eligible employee or retiree who declines healthcare coverage through his/her employer for a plan year. Often the employee obtains healthcare coverage through another means, typically a spouse's employer or an individual.

# APPENDICES

## Appendix A – Plan Design Provisions

### 2002 Public Employee Health Insurance Program Benefit Provisions

| HMO Plans | | Option A | Option B |
|---|---|---|---|
| **Annual Deductible** | | None | None |
| **Maximum out-of-pocket for Covered Expenses** | Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $1,000<br>Family: $2,000 | Single: $1,500<br>Family: $3,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.) | $100 co-pay | $250 co-pay |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay | $20 co-pay |
| | Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay | $20 co-pay |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $50 co-pay | $125 co-pay |
| **Emergency Services** | Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full. | $50 co-pay | $50 co-pay |
| | Urgent Care Center (not hospital emergency room) (per visit) | $20 co-pay | $30 co-pay |
| | Ambulance (per use) | 20% co-insurance | 25% co-insurance |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed | $10 co-pay<br><br>Hospital in-patient co-pay also applies. | $20 co-pay<br><br>Hospital in-patient co-pay also applies. |
| **Prescription Drugs** | Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | $10 generic<br>$15 brand<br>$30 non-formulary |
| **Dental** | Preventive dental only. Limited to two oral exams and two routine cleanings per person, per plan year; one set of bitewing x-rays per person per plan year. | 50% co-insurance;<br>$100 maximum benefit per plan year. | Not covered |
| **Vision** | One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older. | 50% co-insurance;<br>$75 maximum benefit per plan year. | Not covered |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness, or injury. | 50% co-insurance | Not covered |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay | $20 co-pay |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-insurance | 25% co-insurance |
| | Home Health | 20% co-insurance;<br>Limit 60 visits per year. | 25% co-insurance;<br>Limit 40 visits per year. |
| | Hospice–Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit. | Covered same as Medicare benefit. |
| | Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care. | 50% co-insurance | 50% co-insurance |
| | Physical Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Speech Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Skilled Nursing Facility (per admission)–Limit 30 days per year. | $100 co-pay | $250 co-pay |

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

## 2002 Public Employee Health Insurance Program Benefit Provisions (continued)

| POS Plans | | Option A | | Option B | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | None | Single: $500<br>Family: $1,000 | None | Single: $1,000<br>Family: $2,000 |
| **Maximum Out-of-Pocket for Covered Expenses (including deductible)** | Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $1,000<br>Family: $2,000 | Single: $2,500<br>Family: $5,000 | Single: $1,500<br>Family: $3,000 | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. | $100 co-pay<br>(per admission) | 40% co-ins* | $250 co-pay<br>(per admission) | 50% co-ins* |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $50 co-pay<br>(per visit) | 40% co-ins* | $125 co-pay<br>(per visit) | 50% co-ins* |
| **Emergency Services** | Hospital Emergency Room–$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies. | $50 co-pay<br>(per visit) | $50 co-pay plus<br>40% co-ins | $50 co-pay<br>(per visit) | $50 co-pay plus<br>50% co-ins |
| | Emergency Room Physician | Covered in full | 40% co-ins | Covered in full | 50% co-ins |
| | Urgent Care Center (not hospital emergency room) | $20 co-pay<br>(per visit) | 40% co-ins* | $30 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulance (per use) | 20% co-ins | 20% co-ins* | 25% co-ins | 25% co-ins* |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed | $10 co-pay<br><br>Hospital in-patient co-pay also applies. | 40% co-ins*<br><br>Hospital in-patient co-ins* also applies. | $20 co-pay<br><br>Hospital in-patient co-pay also applies. | 50% co-ins*<br><br>Hospital in-patient co-ins* also applies. |
| **Prescription Drugs** | Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | 40% co-ins* | $10 generic<br>$15 brand<br>$30 non-formulary | 50% co-ins* |
| **Dental** | Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year. | 50% co-ins<br>$100 maximum benefit per year | | Not covered | |
| **Vision** | One routine eye exam visit per plan year for persons under 18.<br>One routine eye exam every other year for persons 18 and older. | 50% co-ins<br>$75 maximum benefit per year | | Not covered | |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness, or injury. | 50% co-ins | | Not covered | |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | Home Health | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | | Limit 60 visits per year. | | Limit 40 visits per year. | |
| | Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care. | 50% co-insurance | 50% co-insurance* | 50% co-insurance | 50% co-insurance* |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit |
| | Physical Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Speech Therapy (per visit) –Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Skilled Nursing Facility (per admission) –Limit 30 days per year. | $100 co-pay | 40% co-ins* | $250 co-pay | 50% co-ins* |

## 2002 Public Employee Health Insurance Program Benefit Provisions (continued)

| PPO Plans | | Option A | | Option B | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | Single: $250<br>Family: $500 | Single: $500<br>Family: $1,000 | Single: $500<br>Family: $1,000 | Single: $1,000<br>Family: $2,000 |
| **Maximum out-of-pocket for Covered Expenses (including deductible)** | Co-payments for office visits, hospital emergency room visits, urgent care center visits and coinsurance amounts for dental, vision, audiometric and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. | Single: $1,250<br>Family: $2,500 | Single: $2,500<br>Family: $5,000 | Single: $2,000<br>Family: $4,000 | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay<br>(per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | | $400 maximum benefit per year | | $300 maximum benefit per year | |
| | Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply. | $10 co-pay (per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| **Emergency Services** | Hospital Emergency Room–$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies. | $50 co-pay plus<br>20% co-ins | $50 co-pay plus<br>40% co-ins | $50 co-pay plus<br>25% co-ins | $50 co-pay plus<br>50% co-ins |
| | Emergency Room Physician | 20% co-ins | 40% co-ins | 25% co-ins | 50% co-ins |
| | Urgent Care Center (not hospital emergency room) | $20 co-pay<br>(per visit) | 40% co-ins* | $30 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulance (per use) | 20% co-ins* | 20% co-ins* | 25% co-ins* | 25% co-ins* |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed. | $10 co-pay<br>Hospital in-patient co-ins also applies.* | 40% co-ins* | 25% co-ins*<br>Hospital in-patient co-ins also applies.* | 50% co-ins* |
| **Prescription Drugs** | Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | 40% co-ins* | $10 generic<br>$15 brand<br>$30 non-formulary | 50% co-ins* |
| **Dental** | Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year. | 50% co-ins*<br>$100 maximum benefit per year | | Not covered | |
| **Vision** | One routine eye exam visit per plan year for persons under 18.<br>One routine eye exam every other year for persons 18 and older. | 50% co-ins*<br>$75 maximum benefit per year | | Not covered | |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness or injury. | 50% co-ins* | | Not covered | |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay<br>(per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Home Health | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | | Limit 60 visits per year. | | Limit 40 visits per year. | |
| | Autism Respite Services–$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care. | 50% co-ins* | 50% co-ins* | 50% co-ins* | 50% co-ins* |
| | Hospice–Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit |
| | Physical Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Speech Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Skilled Nursing Facility (per visit)–Limit 30 days per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |

## 2002 Public Employee Health Insurance Program Benefit Provisions (continued)

| Exclusive Provider Option | | Option C |
|---|---|---|
| **Annual Deductible** | | None |
| **Maximum out-of-pocket for Covered Expenses** | Coinsurance amounts for autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.) | $1,500 co-pay (per admission) |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay. | $25 co-pay (per visit) |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $500 co-pay (per visit) |
| | Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply. | $25 co-pay (per visit) |
| | Preventive Testing*–Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA. | 50% co-insurance |
| | Immunizations*–All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults. | 50% co-insurance |
| **Emergency Services** | Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full. | $75 co-pay (per visit) |
| | Urgent Care Center (not hospital emergency room) (per visit) | $50 co-pay (per visit) |
| | Ambulance (per use) | $75 co-pay (per visit) |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. | $25 co-pay (per visit)<br>Hospital in-patient co-pay also applies. |
| **Prescription Drugs** | Copay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services. | $25 generic<br>$35 brand<br>$50 non-formulary |
| **Dental** | | Not covered |
| **Vision** | | Not covered |
| **Other Services** | Audiometric | Not covered |
| | Chiropractor (per visit)–No referral is necessary. Limit of 15 visits per year. No more than one visit per day. | 50% co-insurance<br>Limit 15 visits per year. |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 50% coinsurance |
| | Home Health | Covered in full.<br>Limit 20 visits per year. |
| | Autism Respite Services–$500 maximum monthly benefit for children 2 - 21 years of age for respite and rehabilitative care. | 50% co-insurance |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit. |
| | Physical Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Occupational Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Speech Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Skilled Nursing Facility (per admission)–Limit 20 days per year. | $1,500 co-pay |

## 2003 Public Employee Health Insurance Program Benefit Provisions

| HMO Plans | | Option A | Option B |
|---|---|---|---|
| **Annual Deductible** | | None | None |
| **Maximum out-of-pocket for Covered Expenses** | Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $1,000<br>Family: $2,000 | Single: $1,500<br>Family: $3,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.) | $100 co-pay | $250 co-pay |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay | $20 co-pay |
| | Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay | $20 co-pay |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $50 co-pay | $125 co-pay |
| **Emergency Services** | Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full. | $50 co-pay | $50 co-pay |
| | Urgent Care Center (not hospital emergency room) (per visit) | $20 co-pay | $30 co-pay |
| | Ambulance (per use) | 20% co-insurance | 25% co-insurance |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed | $10 co-pay<br><br>Hospital in-patient co-pay also applies. | $20 co-pay<br><br>Hospital in-patient co-pay also applies. |
| **Prescription Drugs**<br>**Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | $10 generic<br>$15 brand<br>$30 non-formulary |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | $20 generic<br>$30 brand<br>$60 non-formulary |
| **Dental** | | Not Covered | Not covered |
| **Vision** | | Not Covered | Not covered |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness, or injury. | 50% co-insurance | Not covered |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay | $20 co-pay |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-insurance | 25% co-insurance |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-insurance | 25% co-insurance |
| | Home Health | 20% co-insurance;<br>Limit 60 visits per year. | 25% co-insurance;<br>Limit 40 visits per year. |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit. | Covered same as Medicare benefit. |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br>$10 co-pay<br>50% co-insurance | <br>$20 co-pay<br>50% co-insurance |
| | Physical Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Speech Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Skilled Nursing Facility (per admission)–Limit 30 days per year. | $100 co-pay | $250 co-pay |

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

## 2003 Public Employee Health Insurance Program Benefit Provisions (continued)

| POS Plans | | Option A | | Option B | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | None | Single: $500<br>Family: $1,000 | None | Single: $1,000<br>Family: $2,000 |
| **Maximum Out-of-Pocket for Covered Expenses (including deductible)** | Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $1,000<br>Family: $2,000 | Single: $2,500<br>Family: $5,000 | Single: $1,500<br>Family: $3,000 | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. | $100 co-pay<br>(per admission) | 40% co-ins* | $250 co-pay<br>(per admission) | 50% co-ins* |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $50 co-pay<br>(per visit) | 40% co-ins* | $125 co-pay<br>(per visit) | 50% co-ins* |
| **Emergency Services** | Hospital Emergency Room–$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies. | $50 co-pay<br>(per visit) | $50 co-pay plus<br>40% co-ins | $50 co-pay<br>(per visit) | $50 co-pay plus<br>50% co-ins |
| | Emergency Room Physician | Covered in full | 40% co-ins | Covered in full | 50% co-ins |
| | Urgent Care Center (not hospital emergency room) | $20 co-pay<br>(per visit) | 40% co-ins* | $30 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulance (per use) | 20% co-ins | 20% co-ins* | 25% co-ins | 25% co-ins* |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed | $10 co-pay<br>Hospital in-patient co-pay also applies. | 40% co-ins*<br>Hospital in-patient co-ins* also applies. | $20 co-pay<br>Hospital in-patient co-pay also applies. | 50% co-ins*<br>Hospital in-patient co-ins* also applies. |
| **Prescription Drugs**<br>Retail | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | 40% co-ins* | $10 generic<br>$15 brand<br>$30 non-formulary | 50% co-ins* |
| Mail Order | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | | $20 generic<br>$30 brand<br>$60 non-formulary | |
| **Dental** | | Not Covered | | Not covered | |
| **Vision** | | Not Covered | | Not covered | |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness, or injury. | 50% co-ins | | Not covered | |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | Home Health | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | | Limit 60 visits per year. | | Limit 40 visits per year. | |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br><br>$10 co-pay<br>50% co-insurance | <br><br>40% co-ins*<br>50% co-insurance* | <br><br>$20 co-pay<br>50% co-insurance | <br><br>50% co-ins*<br>50% co-insurance* |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit |
| | Physical Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Speech Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Skilled Nursing Facility (per admission)–Limit 30 days per year. | $100 co-pay | 40% co-ins* | $250 co-pay | 50% co-ins* |

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

## 2003 Public Employee Health Insurance Program Benefit Provisions (continued)

| PPO Plans | | Option A | | Option B | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | Single: $250<br>Family: $500 | Single: $500<br>Family: $1,000 | Single: $500<br>Family: $1,000 | Single: $1,000<br>Family: $2,000 |
| **Maximum out-of-pocket for Covered Expenses (including deductible)** | Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. | Single: $1,250<br>Family: $2,500 | Single: $2,500<br>Family: $5,000 | Single: $2,000<br>Family: $4,000 | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay (per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply. | $10 co-pay (per visit) | 40% co-ins* | $20 co-pay (per visit) | 50% co-ins* |
| | | $400 maximum benefit per year | | $300 maximum benefit per year | |
| | Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay (per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| **Emergency Services** | Hospital Emergency Room–$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies. | $50 co-pay plus 20% co-ins | $50 co-pay plus 40% co-ins | $50 co-pay plus 25% co-ins | $50 co-pay plus 50% co-ins |
| | Emergency Room Physician | 20% co-ins | 40% co-ins | 25% co-ins | 50% co-ins |
| | Urgent Care Center (not hospital emergency room) | $20 co-pay (per visit) | 40% co-ins* | $30 co-pay (per visit) | 50% co-ins* |
| | Ambulance (per use) | 20% co-ins* | 20% co-ins* | 25% co-ins* | 25% co-ins* |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed. | $10 co-pay Hospital in-patient co-ins also applies.* | 40% co-ins* | 25% co-ins* Hospital in-patient co-ins also applies.* | 50% co-ins* |
| **Prescription Drugs Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | 40% co-ins* | $10 generic<br>$15 brand<br>$30 non-formulary | 50% co-ins* |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | | $20 generic<br>$30 brand<br>$60 non-formulary | |
| **Dental** | | Not Covered | | Not covered | |
| **Vision** | | Not Covered | | Not covered | |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness or injury. | 50% co-ins* | | Not covered | |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay (per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Home Health | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | | Limit 60 visits per year. | | Limit 40 visits per year. | |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br><br>$10 co-pay<br>50% co-ins* | <br><br>40% co-ins*<br>50% co-ins* | <br><br>25% co-ins*<br>50% co-ins* | <br><br>50% co-ins*<br>50% co-ins* |
| | Hospice–Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit |
| | Physical Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Speech Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Skilled Nursing Facility (per visit)–Limit 30 days per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Prior approval may be required for some services. Please contact your Carrier.

## 2003 Public Employee Health Insurance Program Benefit Provisions (continued)

| EPO Plan | | |
|---|---|---|
| **Annual Deductible** | | None |
| **Maximum out-of-pocket for Covered Expenses** | Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.) | $1,500 co-pay (per admission) |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay. | $25 co-pay (per visit) |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $500 co-pay (per visit) |
| | Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $25 co-pay (per visit) |
| | Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA. | 50% co-insurance |
| | Immunizations*–All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults. | 50% co-insurance |
| **Emergency Services** | Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full. | $75 co-pay (per visit) |
| | Urgent Care Center (not hospital emergency room) (per visit) | $50 co-pay (per visit) |
| | Ambulance (per use) | $75 co-pay (per visit) |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. | $25 co-pay (per visit)<br>Hospital in-patient co-pay also applies. |
| **Prescription Drugs**<br>**Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services. | $25 generic<br>$35 brand<br>$50 non-formulary |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $50 generic<br>$70 brand<br>$100 non-formulary |
| **Dental** | | Not covered |
| **Vision** | | Not covered |
| **Other Services** | Audiometric | Not covered |
| | Chiropractor (per visit)–No referral is necessary. Limit of 15 visits per year. No more than one visit per day. | 50% co-insurance<br>Limit 15 visits per year. |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 50% coinsurance |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 50% coinsurance |
| | Home Health | Covered in full.<br>Limit 20 visits per year. |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br>$25 co-pay (per visit)<br>50% co-insurance |
| | Hospice–Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit. |
| | Physical Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Occupational Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Speech Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Skilled Nursing Facility (per admission)–Limit 20 days per year. | $1,500 co-pay |

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered. Referrals and/or prior approval may be required for some services. Please contact your Carrier.

## 2003 Public Employee Health Insurance Program Benefit Provisions (continued)

| HMO Plans | | Option A | Option B |
|---|---|---|---|
| **Annual Deductible** | | None | None |
| **Maximum out-of-pocket for Covered Expenses** | Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $1,000<br>Family: $2,000 | Single: $1,500<br>Family: $3,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.) | $100 co-pay | $250 co-pay |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay | $20 co-pay |
| | Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay | $20 co-pay |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $50 co-pay | $125 co-pay |
| **Emergency Services** | Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full. | $50 co-pay | $50 co-pay |
| | Urgent Care Center (not hospital emergency room) (per visit) | $20 co-pay | $30 co-pay |
| | Ambulance (per use) | 20% co-insurance | 25% co-insurance |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed | $10 co-pay<br><br>Hospital in-patient co-pay also applies. | $20 co-pay<br><br>Hospital in-patient co-pay also applies. |
| **Prescription Drugs**<br>**Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | $10 generic<br>$15 brand<br>$30 non-formulary |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | $20 generic<br>$30 brand<br>$60 non-formulary |
| **Dental** | | Not Covered | Not covered |
| **Vision** | | Not Covered | Not covered |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness, or injury. | 50% co-insurance | Not covered |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay | $20 co-pay |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-insurance | 25% co-insurance |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-insurance | 25% co-insurance |
| | Home Health | 20% co-insurance;<br>Limit 60 visits per year. | 25% co-insurance;<br>Limit 40 visits per year. |
| | Hospice–Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit. | Covered same as Medicare benefit. |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br>$10 co-pay<br>50% co-insurance | <br>$20 co-pay<br>50% co-insurance |
| | Physical Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Speech Therapy (per visit) – Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Skilled Nursing Facility (per admission) – Limit 30 days per year. | $100 co-pay | $250 co-pay |

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

## 2003 Public Employee Health Insurance Program Benefit Provisions (continued)

| POS Plans | | Option A | | Option B | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | None | Single: $500<br>Family: $1,000 | None | Single: $1,000<br>Family: $2,000 |
| **Maximum Out-of-Pocket for Covered Expenses (including deductible)** | Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $1,000<br>Family: $2,000 | Single: $2,500<br>Family: $5,000 | Single: $1,500<br>Family: $3,000 | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. | $100 co-pay<br>(per admission) | 40% co-ins* | $250 co-pay<br>(per admission) | 50% co-ins* |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $50 co-pay<br>(per visit) | 40% co-ins* | $125 co-pay<br>(per visit) | 50% co-ins* |
| **Emergency Services** | Hospital Emergency Room–$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies. | $50 co-pay<br>(per visit) | $50 co-pay plus<br>40% co-ins | $50 co-pay<br>(per visit) | $50 co-pay plus<br>50% co-ins |
| | Emergency Room Physician | Covered in full | 40% co-ins | Covered in full | 50% co-ins |
| | Urgent Care Center (not hospital emergency room) | $20 co-pay<br>(per visit) | 40% co-ins* | $30 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulance (per use) | 20% co-ins | 20% co-ins* | 25% co-ins | 25% co-ins* |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed | $10 co-pay<br>Hospital in-patient co-pay also applies. | 40% co-ins*<br>Hospital in-patient co-ins* also applies. | $20 co-pay<br>Hospital in-patient co-pay also applies. | 50% co-ins*<br>Hospital in-patient co-ins* also applies. |
| **Prescription Drugs**<br>Retail | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | 40% co-ins* | $10 generic<br>$15 brand<br>$30 non-formulary | 50% co-ins* |
| Mail Order | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | | $20 generic<br>$30 brand<br>$60 non-formulary | |
| **Dental** | | Not Covered | | Not covered | |
| **Vision** | | Not Covered | | Not covered | |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness, or injury. | 50% co-ins | | Not covered | |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | Home Health | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | | Limit 60 visits per year. | | Limit 40 visits per year. | |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | $10 co-pay<br>50% co-insurance | 40% co-ins*<br>50% co-insurance* | $20 co-pay<br>50% co-insurance | 50% co-ins*<br>50% co-insurance* |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit |
| | Physical Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Speech Therapy (per visit) –Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Skilled Nursing Facility (per admission) –Limit 30 days per year. | $100 co-pay | 40% co-ins* | $250 co-pay | 50% co-ins* |

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

## 2003 Public Employee Health Insurance Program Benefit Provisions (continued)

| PPO Plans | | Option A | | Option B | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | Single: $250<br>Family: $500 | Single: $500<br>Family: $1,000 | Single: $500<br>Family: $1,000 | Single: $1,000<br>Family: $2,000 |
| **Maximum out-of-pocket for Covered Expenses (including deductible)** | Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. | Single: $1,250<br>Family: $2,500 | Single: $2,500<br>Family: $5,000 | Single: $2,000<br>Family: $4,000 | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay<br>(per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | | $400 maximum benefit per year | | $300 maximum benefit per year | |
| | Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay (per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| **Emergency Services** | Hospital Emergency Room–$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies. | $50 co-pay plus<br>20% co-ins | $50 co-pay plus<br>40% co-ins | $50 co-pay plus<br>25% co-ins | $50 co-pay plus<br>50% co-ins |
| | Emergency Room Physician | 20% co-ins | 40% co-ins | 25% co-ins | 50% co-ins |
| | Urgent Care Center (not hospital emergency room) | $20 co-pay<br>(per visit) | 40% co-ins* | $30 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulance (per use) | 20% co-ins* | 20% co-ins* | 25% co-ins* | 25% co-ins* |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed. | $10 co-pay<br>Hospital in-patient co-ins also applies.* | 40% co-ins* | 25% co-ins*<br>Hospital in-patient co-ins also applies.* | 50% co-ins* |
| **Prescription Drugs Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | 40% co-ins* | $10 generic<br>$15 brand<br>$30 non-formulary | 50% co-ins* |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | | $20 generic<br>$30 brand<br>$60 non-formulary | |
| **Dental** | | Not Covered | | Not covered | |
| **Vision** | | Not Covered | | Not covered | |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness or injury. | 50% co-ins* | | Not covered | |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay<br>(per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Home Health | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | | Limit 60 visits per year. | | Limit 40 visits per year. | |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br>$10 co-pay<br>50% co-ins* | <br>40% co-ins*<br>50% co-ins* | <br>25% co-ins*<br>50% co-ins* | <br>50% co-ins*<br>50% co-ins* |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit |
| | Physical Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Speech Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Skilled Nursing Facility (per visit)–Limit 30 days per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Prior approval may be required for some services. Please contact your Carrier.

## 2003 Public Employee Health Insurance Program Benefit Provisions (continued)

| EPO Plan | | |
|---|---|---|
| **Annual Deductible** | | None |
| **Maximum out-of-pocket for Covered Expenses** | Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.) | $1,500 co-pay (per admission) |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam–visit only–see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay. | $25 co-pay (per visit) |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $500 co-pay (per visit) |
| | Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $25 co-pay (per visit) |
| | Preventive Testing*–Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA. | 50% co-insurance |
| | Immunizations*–All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults. | 50% co-insurance |
| **Emergency Services** | Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full. | $75 co-pay (per visit) |
| | Urgent Care Center (not hospital emergency room) (per visit) | $50 co-pay (per visit) |
| | Ambulance (per use) | $75 co-pay (per visit) |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. | $25 co-pay (per visit)<br>Hospital in-patient co-pay also applies. |
| **Prescription Drugs Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services. | $25 generic<br>$35 brand<br>$50 non-formulary |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $50 generic<br>$70 brand<br>$100 non-formulary |
| **Dental** | | Not covered |
| **Vision** | | Not covered |
| **Other Services** | Audiometric | Not covered |
| | Chiropractor (per visit)–No referral is necessary. Limit of 15 visits per year. No more than one visit per day. | 50% co-insurance<br>Limit 15 visits per year. |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 50% coinsurance |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 50% coinsurance |
| | Home Health | Covered in full.<br>Limit 20 visits per year. |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br>$25 co-pay (per visit)<br>50% co-insurance |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit. |
| | Physical Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Occupational Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Speech Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Skilled Nursing Facility (per admission)–Limit 20 days per year. | $1,500 co-pay |

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

## 2004 Public Employee Health Insurance Program Benefit Provisions

| HMO Plans | | Option A | Option B |
|---|---|---|---|
| **Annual Deductible** | | None | None |
| **Maximum out-of-pocket for Covered Expenses** | Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $1,000<br>Family: $2,000 | Single: $1,500<br>Family: $3,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.) | $100 co-pay | $250 co-pay |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay | $20 co-pay |
| | Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay | $20 co-pay |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $50 co-pay | $125 co-pay |
| **Emergency Services** | Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full. | $50 co-pay | $50 co-pay |
| | Urgent Care Center (not hospital emergency room) (per visit) | $20 co-pay | $30 co-pay |
| | Ambulance (per use) | 20% co-insurance | 25% co-insurance |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed | $10 co-pay<br><br>Hospital in-patient co-pay also applies. | $20 co-pay<br><br>Hospital in-patient co-pay also applies. |
| **Prescription Drugs**<br>**Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | $10 generic<br>$15 brand<br>$30 non-formulary |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | $20 generic<br>$30 brand<br>$60 non-formulary |
| **Dental** | | Not Covered | Not covered |
| **Vision** | | Not Covered | Not covered |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness, or injury. | 50% co-insurance | Not covered |
| | Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay | $20 co-pay |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-insurance | 25% co-insurance |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-insurance | 25% co-insurance |
| | Home Health | 20% co-insurance;<br>Limit 60 visits per year. | 25% co-insurance;<br>Limit 40 visits per year. |
| | Hospice–Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit. | Covered same as Medicare benefit. |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age | | |
| | • Rehabilitative and Therapeutic care | $10 co-pay | $20 co-pay |
| | • Respite Care | 50% co-insurance | 50% co-insurance |
| | Physical Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Speech Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | $20 co-pay |
| | Skilled Nursing Facility (per admission)–Limit 30 days per year. | $100 co-pay | $250 co-pay |

## 2004 Public Employee Health Insurance Program Benefit Provisions (continued)

| POS Plans | | Option A | | Option B | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | None | Single: $500<br>Family: $1,000 | None | Single: $1,000<br>Family: $2,000 |
| **Maximum Out-of-Pocket for Covered Expenses (including deductible)** | Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $1,000<br>Family: $2,000 | Single: $2,500<br>Family: $5,000 | Single: $1,500<br>Family: $3,000 | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. | $100 co-pay<br>(per admission) | 40% co-ins* | $250 co-pay<br>(per admission) | 50% co-ins* |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $50 co-pay<br>(per visit) | 40% co-ins* | $125 co-pay<br>(per visit) | 50% co-ins* |
| **Emergency Services** | Hospital Emergency Room–$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies. | $50 co-pay<br>(per visit) | $50 co-pay plus<br>40% co-ins | $50 co-pay<br>(per visit) | $50 co-pay plus<br>50% co-ins |
| | Emergency Room Physician | Covered in full | 40% co-ins | Covered in full | 50% co-ins |
| | Urgent Care Center (not hospital emergency room) | $20 co-pay<br>(per visit) | 40% co-ins* | $30 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulance (per use) | 20% co-ins | 20% co-ins* | 25% co-ins | 25% co-ins* |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed | $10 co-pay<br>Hospital in-patient co-pay also applies. | 40% co-ins*<br>Hospital in-patient co-ins* also applies. | $20 co-pay<br>Hospital in-patient co-pay also applies. | 50% co-ins*<br>Hospital in-patient co-ins* also applies. |
| **Prescription Drugs**<br><br>Retail | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | 40% co-ins* | $10 generic<br>$15 brand<br>$30 non-formulary | 50% co-ins* |
| Mail Order | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | | $20 generic<br>$30 brand<br>$60 non-formulary | |
| **Dental** | | Not Covered | | Not covered | |
| **Vision** | | Not Covered | | Not covered | |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness, or injury. | 50% co-ins | | Not covered | |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | Home Health | 20% co-ins | 40% co-ins* | 25% co-ins | 50% co-ins* |
| | | Limit 60 visits per year. | | Limit 40 visits per year. | |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br><br>• Rehabilitative and Therapeutic care<br><br>• Respite Care | <br><br>$10 co-pay<br><br>50% co-insurance | <br><br>40% co-ins*<br><br>50% co-insurance* | <br><br>$20 co-pay<br><br>50% co-insurance | <br><br>50% co-ins*<br><br>50% co-insurance* |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit |
| | Physical Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Speech Therapy (per visit)–Limit 30 visits per year. | $10 co-pay | 40% co-ins* | $20 co-pay | 50% co-ins* |
| | Skilled Nursing Facility (per admission)–Limit 30 days per year. | $100 co-pay | 40% co-ins* | $250 co-pay | 50% co-ins* |

## 2004 Public Employee Health Insurance Program Benefit Provisions (continued)

| PPO Plans | | Option A | | Option B | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | Single: $250<br>Family: $500 | Single: $500<br>Family: $1,000 | Single: $500<br>Family: $1,000 | Single: $1,000<br>Family: $2,000 |
| **Maximum out-of-pocket for Covered Expenses (including deductible)** | Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. | Single: $1,250<br>Family: $2,500 | Single: $2,500<br>Family: $5,000 | Single: $2,000<br>Family: $4,000 | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited | Unlimited | Unlimited | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay. | $10 co-pay<br>(per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply. | $10 co-pay<br>(per visit) | 40% co-ins* | $20 co-pay<br>(per visit) | 50% co-ins* |
| | | $400 maximum benefit per year | | $300 maximum benefit per year | |
| | Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $10 co-pay (per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| **Emergency Services** | Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies. | $50 co-pay plus<br>20% co-ins | $50 co-pay plus<br>40% co-ins | $50 co-pay plus<br>25% co-ins | $50 co-pay plus<br>50% co-ins |
| | Emergency Room Physician | 20% co-ins | 40% co-ins | 25% co-ins | 50% co-ins |
| | Urgent Care Center (not hospital emergency room) | $20 co-pay<br>(per visit) | 40% co-ins* | $30 co-pay<br>(per visit) | 50% co-ins* |
| | Ambulance (per use) | 20% co-ins* | 20% co-ins* | 25% co-ins* | 25% co-ins* |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed. | $10 co-pay<br>Hospital in-patient co-ins also applies.* | 40% co-ins* | 25% co-ins*<br>Hospital in-patient co-ins also applies.* | 50% co-ins* |
| **Prescription Drugs Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $10 generic<br>$15 brand<br>$30 non-formulary | 40% co-ins* | $10 generic<br>$15 brand<br>$30 non-formulary | 50% co-ins* |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $20 generic<br>$30 brand<br>$60 non-formulary | | $20 generic<br>$30 brand<br>$60 non-formulary | |
| **Dental** | | Not Covered | | Not covered | |
| **Vision** | | Not Covered | | Not covered | |
| **Other Services** | Audiometric–Only covered in conjunction with a disease, illness or injury. | 50% co-ins* | | Not covered | |
| | Chiropractor (per visit)–No referral is necessary. Limit of 26 visits per year with no more than one visit per day. | $10 co-pay<br>(per visit) | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Home Health | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | | Limit 60 visits per year. | | Limit 40 visits per year. | |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br>$10 co-pay<br>50% co-ins* | <br>40% co-ins*<br>50% co-ins* | <br>25% co-ins*<br>50% co-ins* | <br>50% co-ins*<br>50% co-ins* |
| | Hospice–Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit | Covered same as Medicare benefit |
| | Physical Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Occupational Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Speech Therapy (per visit)–Limit 30 visits per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |
| | Skilled Nursing Facility (per visit)–Limit 30 days per year. | 20% co-ins* | 40% co-ins* | 25% co-ins* | 50% co-ins* |

## 2004 Public Employee Health Insurance Program Benefit Provisions (continued)

| EPO Plan | | |
|---|---|---|
| **Annual Deductible** | | None |
| **Maximum out-of-pocket for Covered Expenses** | Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply. | Single: $4,000<br>Family: $8,000 |
| **Lifetime Maximum Benefit** | | Unlimited |
| **In Hospital Care** | Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.) | $1,500 co-pay (per admission) |
| **Outpatient Services** | Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay. | $25 co-pay (per visit) |
| | Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office). | $500 co-pay (per visit) |
| | Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply. | $25 co-pay (per visit) |
| | Preventive Testing*–Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA. | 50% co-insurance |
| | Immunizations*–All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults. | 50% co-insurance |
| **Emergency Services** | Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full. | $75 co-pay (per visit) |
| | Urgent Care Center (not hospital emergency room) (per visit) | $50 co-pay (per visit) |
| | Ambulance (per use) | $75 co-pay (per visit) |
| **Maternity Care** | Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. | $25 co-pay (per visit)<br>Hospital in-patient co-pay also applies. |
| **Prescription Drugs Retail** | Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services. | $25 generic<br>$35 brand<br>$50 non-formulary |
| **Mail Order** | Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services. | $50 generic<br>$70 brand<br>$100 non-formulary |
| **Dental** | | Not covered |
| **Vision** | | Not covered |
| **Other Services** | Audiometric | Not covered |
| | Chiropractor (per visit)–No referral is necessary. Limit of 15 visits per year. No more than one visit per day. | 50% co-insurance<br>Limit 15 visits per year. |
| | Durable Medical Equipment (DME) and Prosthetic Devices | 50% coinsurance |
| | Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.) | 50% coinsurance |
| | Home Health | Covered in full.<br>Limit 20 visits per year. |
| | Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age<br>• Rehabilitative and Therapeutic care<br>• Respite Care | <br>$25 co-pay (per visit)<br>50% co-insurance |
| | Hospice – Certain limits apply. Must be precertified by Plan. | Covered same as Medicare benefit. |
| | Physical Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Occupational Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Cardiac Rehabilitation Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Speech Therapy (per visit)–Limit 20 visits per year. | $30 co-pay (per visit) |
| | Skilled Nursing Facility (per admission)–Limit 20 days per year. | $1,500 co-pay |

# 2005 Public Employee Health Insurance Program Benefit Provisions

| Covered Services | Commonwealth Essential | |
|---|---|---|
| | In-Network | Out-of-Network |
| Annual Deductible | Single - $750<br>Family - $1,500 | Single - $1,500<br>Family - $3,000 |
| Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments) | Single - $3,500<br>Family - $7,000 | Single - $7,000<br>Family - $14,000 |
| Lifetime maximum | Unlimited | |
| In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services | 25%* | 50%* |
| Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site). | 25%* | 50%* |
| Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site). | 25%* | 50%* |
| Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office. | 25%* | 50%* |
| Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits. | Plan pays 100% up to a maximum of $200 per covered individual. Plan pays 100% of eligible immunizations. | |
| Emergency services | | |
| Emergency room treatment (Emergency room co-pay waived if admitted). | $50 co-pay plus 25%* | $50 co-pay plus 50%* |
| Emergency room physician charges | 25%* | 50%* |
| Urgent care center treatment | 25%* | 50%* |
| Ambulance services | 25%* | 50%* |
| Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. | 25%* | 50%* |
| Prescription drugs – Retail (30 day supply)<br><br>Generic<br>Preferred Brand<br>Non-preferred Brand | 25%<br>Min / Max<br>$10 / $25<br>$20 / $50<br>$35 / $100 | |
| Prescription drugs – Mail Order (90 day supply)<br><br>Generic<br>Preferred Brand<br>Non-preferred Brand | 25%<br>Min / Max<br>$20 / $50<br>$40 / $100<br>$70 / $200 | |
| Audiometric services in conjunction with a disease, illness or injury | 25%* | 50%* |
| Chiropractic services – limited to 26 visits per year, with no more than one visit per day | 25%* | 50%* |
| Autism Service | | |
| Rehabilitative and therapeutic care services | 25%* | 50%* |
| Respite care for children ages two through 21 ($500 maximum per month) | 25%* | 50%* |
| Hospice care – subject to precertification by the plan | Covered the same as under the federal Medicare program | |
| Durable Medical Equipment | 25%* | 50%* |
| Prosthetic devices | 25%* | 50%* |
| Home health – limited to 60 visits per year | 25%* | 50%* |
| Physical therapy – limited to 30 visits per year | 25%* | 50%* |
| Occupational therapy – limited to 30 visits per year | 25%* | 50%* |
| Cardiac rehabilitation therapy – limited to 30 visits per year | 25%* | 50%* |
| Speech therapy – limited to 30 visits per year | 25%* | 50%* |
| Skilled nursing facility services – limited to 30 days per year | 25%* | 50%* |
| Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear | 25%* | 50%* |

*services subject to deductible

# 2005 Public Employee Health Insurance Program Benefit Provisions (Continued)

| Covered Services | Commonwealth Enhanced | | Commonwealth Premier | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services) | Single - $250<br>Family - $500 | Single - $500<br>Family - $1,000 | Single - $250<br>Family - $500 | Single - $500<br>Family - $1,000 |
| Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services) | Single - $1,250<br>Family - $2,500 | Single - $2,500<br>Family - $5,000 | Single - $1,000<br>Family - $2,000 | Single - $2,000<br>Family - $4,000 |
| Lifetime maximum | Unlimited | | Unlimited | |
| In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services | 20%* | 40%* | 10%* | 30%* |
| Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site). | $10 co-pay | 40%* | $10 co-pay | 30%* |
| Outpatient diagnostic testing – laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site). | $10 co-pay | 40%* | $10 co-pay | 30%* |
| Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office. | 20%* | 40%* | 10%* | 30%* |
| Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits. | $10 co-pay per visit | 40%* | $10 co-pay per visit | 30%* |
| | $400 maximum benefit per covered individual per plan year | | $400 maximum benefit per covered individual per plan year | |
| Emergency services | | | | |
| Emergency room treatment (Emergency room co-pay waived if admitted). | $50 co-pay plus 20% | $50 co-pay plus 40% | $50 co-pay plus 10% | $50 co-pay plus 30%* |
| Emergency room physician charges | 20% | 40% | 10% | 30%* |
| Urgent care center treatment | $20 co-pay | 40%* | $20 co-pay | 30%* |
| Ambulance services | 20%* | 20%* | 10%* | 30%* |
| Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required. | $10 co-pay<br><br>in-hospital care co-insurance applies* | 40%* | $10 co-pay<br><br>in-hospital care co-insurance applies* | 30%* |
| Prescription drugs – Retail (30 day supply)<br>Generic<br>Preferred Brand<br>Non-preferred Brand | <br>$10**<br>$15**<br>$30** | <br>40%<br>40%<br>40% | <br>$10**<br>$15**<br>$30** | <br>30%<br>30%<br>30% |
| Prescription drugs – Mail Order (90 day supply)<br>Generic<br>Preferred Brand<br>Non-preferred Brand | <br>$20<br>$30<br>$60 | | <br>$20<br>$30<br>$60 | |
| Audiometric services in conjunction with a disease, illness or injury | 50%* | 50%* | 10%* | 30%* |
| Chiropractic services – limited to 26 visits per year, with no more than one visit per day | $10 co-pay | 40%* | $10 co-pay | 30%* |
| Autism Service | | | | |
| ▪ Rehabilitative and therapeutic care services | $10 co-pay | 40%* | $10 co-pay | 30%* |
| ▪ Respite care for children ages two through 21 ($500 maximum per month) | 50%* | 50%* | 10%* | 30%* |
| Hospice care – subject to precertification by the plan | Covered the same as under the federal Medicare program | | Covered the same as under the federal Medicare program | |
| Durable Medical Equipment | 20%* | 40%* | 10%* | 30%* |
| Prosthetic devices | 20%* | 40%* | 10%* | 30%* |
| Home health – limited to 60 visits per year | 20%* | 40%* | 10%* | 30%* |
| Physical therapy – limited to 30 visits per year | 20%* | 40%* | 10%* | 30%* |
| Occupational therapy – limited to 30 visits per year | 20%* | 40%* | 10%* | 30%* |
| Cardiac rehabilitation therapy – limited to 30 visits per year | 20%* | 40%* | 10%* | 30%* |
| Speech therapy – limited to 30 visits per year | 20%* | 40%* | 10%* | 30%* |
| Skilled nursing facility services – limited to 30 days per year | 20%* | 40%* | 10%* | 30%* |
| Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear | 20%* | 40%* | 10%* | 30%* |

* Subject to annual deductible

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $5 generic, $10 preferred brand and $20 non-preferred brand.

# 2006 Public Employee Health Insurance Program Benefit Provisions

| Covered Services | Commonwealth Essential | |
|---|---|---|
| | In-Network | Out-of-Network |
| Annual Deductible | Single - $750<br>Family - $1,500 | Single - $1,500<br>Family - $3,000 |
| Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments) | Single - $3,500<br>Family - $7,000 | Single - $7,000<br>Family - $14,000 |
| Lifetime maximum | Unlimited | |
| In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services | 25%* | 50%* |
| Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site). | 25%* | 50%* |
| Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site). | 25%* | 50%* |
| Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office. | 25%* | 50%* |
| Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits. | Plan pays 100% up to a maximum of $200 per covered individual. Plan pays 100% of eligible immunizations. | |
| Emergency services | | |
| Emergency room treatment (Emergency room co-pay waived if admitted). | $50 co-pay plus 25%* | $50 co-pay plus 50%* |
| Emergency room physician charges | 25%* | 50%* |
| Urgent care center treatment | 25%* | 50%* |
| Ambulance services | 25%* | 50%* |
| Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. | 25%* | 50%* |
| Prescription drugs – Retail (30 day supply)<br><br>Generic<br>Preferred Brand<br>Non-preferred Brand | 25%<br>Min / Max<br>$5 / $25<br>$15 / $50<br>$30 / $100 | |
| Prescription drugs – Mail Order (90 day supply)<br><br>Generic<br>Preferred Brand<br>Non-preferred Brand | 25%<br>Min / Max<br>$10 / $50<br>$30 / $100<br>$60 / $200 | |
| Audiometric services in conjunction with a disease, illness or injury | 25%* | 50%* |
| Chiropractic services – limited to 26 visits per year, with no more than one visit per day | 25%* | 50%* |
| Autism Service | | |
| Rehabilitative and therapeutic care services | 25%* | 50%* |
| Respite care for children ages two through 21 ($500 maximum per month) | 25%* | 50%* |
| Hospice care – subject to precertification by the plan | Covered the same as under the federal Medicare program | |
| Durable Medical Equipment | 25%* | 50%* |
| Prosthetic devices | 25%* | 50%* |
| Home health – limited to 60 visits per year | 25%* | 50%* |
| Physical therapy – limited to 30 visits per year | 25%* | 50%* |
| Occupational therapy – limited to 30 visits per year | 25%* | 50%* |
| Cardiac rehabilitation therapy – limited to 30 visits per year | 25%* | 50%* |
| Speech therapy – limited to 30 visits per year | 25%* | 50%* |
| Skilled nursing facility services – limited to 30 days per year | 25%* | 50%* |
| Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear | 25%* | 50%* |

*services subject to deductible

## 2006 Public Employee Health Insurance Program Benefit Provisions (Continued)

| Covered Services | Commonwealth Enhanced | | Commonwealth Premier | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services) | Single - $250<br>Family - $500 | Single - $500<br>Family - $1,000 | Single - $250<br>Family - $500 | Single - $500<br>Family - $1,000 |
| Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services) | Single - $1,250<br>Family - $2,500 | Single - $2,500<br>Family - $5,000 | Single - $1,000<br>Family - $2,000 | Single - $2,000<br>Family - $4,000 |
| Lifetime maximum | Unlimited | | Unlimited | |
| In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services | 20%* | 40%* | 10%* | 30%* |
| Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site). | $10 co-pay | 40%* | $10 co-pay | 30%* |
| Outpatient diagnostic testing – laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site). | $10 co-pay | 40%* | $10 co-pay | 30%* |
| Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office. | 20%* | 40%* | 10%* | 30%* |
| Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits. | $10 co-pay per visit | 40%* | $10 co-pay per visit | 30%* |
| | $400 maximum benefit per covered individual per plan year | | $400 maximum benefit per covered individual per plan year | |
| Emergency services | | | | |
| Emergency room treatment (Emergency room co-pay waived if admitted). | $50 co-pay plus 20% | $50 co-pay plus 40% | $50 co-pay plus 10% | $50 co-pay plus 30%* |
| Emergency room physician charges | 20% | 40% | 10% | 30%* |
| Urgent care center treatment | $20 co-pay | 40%* | $20 co-pay | 30%* |
| Ambulance services | 20%* | 20%* | 10%* | 30%* |
| Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required. | $10 co-pay<br><br>in-hospital care co-insurance applies* | 40%* | $10 co-pay<br><br>in-hospital care co-insurance applies* | 30%* |
| Prescription drugs – Retail (30 day supply)<br>Generic<br>Preferred Brand<br>Non-preferred Brand | <br>$5**<br>$15**<br>$30** | <br>40%<br>40%<br>40% | <br>$5**<br>$15**<br>$30** | <br>30%<br>30%<br>30% |
| Prescription drugs – Mail Order (90 day supply)<br>Generic<br>Preferred Brand<br>Non-preferred Brand | <br>$10<br>$30<br>$60 | | <br>$10<br>$30<br>$60 | |
| Audiometric services in conjunction with a disease, illness or injury | 50%* | 50%* | 10%* | 30%* |
| Chiropractic services – limited to 26 visits per year, with no more than one visit per day | $10 co-pay | 40%* | $10 co-pay | 30%* |
| Autism Service | | | | |
| ▪ Rehabilitative and therapeutic care services | $10 co-pay | 40%* | $10 co-pay | 30%* |
| ▪ Respite care for children ages two through 21 ($500 maximum per month) | 50%* | 50%* | 10%* | 30%* |
| Hospice care – subject to precertification by the plan | Covered the same as under the federal Medicare program | | Covered the same as under the federal Medicare program | |
| Durable Medical Equipment | 20%* | 40%* | 10%* | 30%* |
| Prosthetic devices | 20%* | 40%* | 10%* | 30%* |
| Home health – limited to 60 visits per year | 20%* | 40%* | 10%* | 30%* |
| Physical therapy – limited to 30 visits per year | 20%* | 40%* | 10%* | 30%* |
| Occupational therapy – limited to 30 visits per year | 20%* | 40%* | 10%* | 30%* |
| Cardiac rehabilitation therapy – limited to 30 visits per year | 20%* | 40%* | 10%* | 30%* |
| Speech therapy – limited to 30 visits per year | 20%* | 40%* | 10%* | 30%* |
| Skilled nursing facility services – limited to 30 days per year | 20%* | 40%* | 10%* | 30%* |
| Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of $1,400 per ear | 20%* | 40%* | 10%* | 30%* |

* Subject to annual deductible

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to $5 generic, $10 preferred brand and $20 non-preferred brand.

## Appendix B – 2005 Geographic Regions

Commonwealth counties were aggregated geographically into eight regions for 2005, where each region was served by a single insurance company's managed care network. The county assignments and assigned carriers are shown below.